

BIRTHING CHANGE:  
AN ETHNOGRAPHIC STUDY OF  
THE ALASKA FAMILY HEALTH & BIRTH CENTER  
IN FAIRBANKS, ALASKA

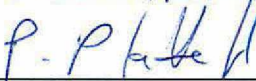
By

Danielle M. Bennett Redmond

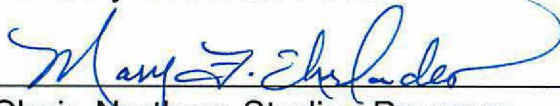
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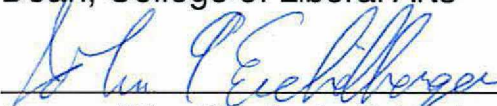


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Dean of the Graduate School



Date

BIRTHING CHANGE: AN ETHNOGRAPHIC STUDY OF  
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A

Thesis

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Danielle M. Bennett Redmond, B.A.

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## **Abstract**

This study examines the practices of the Alaska Family Health & Birth Center in order to understand how midwives help clients navigate the process of pregnancy, birth, and the postpartum period with a high rate of success, as defined by a low cesarean rate, low mortality and morbidity, and high maternal satisfaction. How do the midwives prepare mothers to navigate the transformation and how do they address failure to progress during birth? This study analyzes birth as a rite of passage, which incorporates a culture's worldview and its practices. These outcomes are achieved by employing a positive, holistic view of the natural, physiological process, by using practices that support the physiological process and minimize intervention, and by keeping the space in which out-of hospital birth takes place. The fact that parents are choosing an alternative ritual for birth at an increasing rate nationwide reflects a change happening in American culture.

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## **List of Acronyms**

ACOG	American Congress of Obstetricians & Gynecologists
ACNM	American College of Nurse-Midwives
AFH&BC	Alaska Family Health & Birth Center
ANMC	Alaska Native Medical Center in Anchorage, Alaska
CDC	Centers for Disease Control and Prevention
CNM	Certified Nurse-midwife
CPM	Certified Professional Midwife
DEM	Direct-entry Midwife
DKC	Denali KidCare
FDA	Food and Drug Administration
FMH	Fairbanks Memorial Hospital
GBS	Group B Streptococcus
IRB	Institutional Review Board
LLL	La Leche League
MAA	Midwives Association of Alaska
MANA	Midwives Alliance of North America
NARM	North American Registry of Midwives
NCHS	U.S. National Center for Health Statistics
NICU	Neonatal Intensive Care Unit
NIH	U.S. National Institute of Health
NRA	National Rifle Association
OOH	Out-of-hospital
PPD	Postpartum Depression
UC	Unassisted Childbirth
VBAC	Vaginal Birth After Cesarean
WHO	World Health Organization

## Chapter 1: Introduction

### 1.1 The Alaska Family Health & Birth Center (AFH&BC)

For thirty years, the Alaska Family Health & Birth Center (AFH&BC) has provided pregnancy testing, prenatal care, and out-of-hospital (OOH) birth services to families in Fairbanks, Alaska. The midwives at AFH&BC use “the midwifery model of care,” which is a holistic approach that views pregnancy and birth as normal parts of the life cycle. In 2011, while the national rate of cesarean birth was 32.8 percent (Hamilton, Martin, and Ventura 2012, 2), the cesarean rate at AFH&BC was less than 1 percent.

A 2010 report from the U.S Centers for Disease Control (CDC) showed that Alaska has the highest rate of total OOH birth in the country at 5.3 percent.<sup>1</sup> The authors speculate: “The long distances and severe weather in Alaska may mean that women living in rural areas may not always have easy access to a hospital birth. Cultural factors and personal preferences may also influence women’s choice of birthplace” (MacDorman, Menacker, and Declercq 2010, 6). In the state of Alaska, one out of every nineteen births takes place outside the hospital setting (MacDorman, Menacker, and Declercq 2010, 6). Alaska currently has at least five freestanding birth centers including the Alaska Family Health & Birth Center (AFH&BC).

Nationally, as of 2010, only 1.2 percent of U.S. births in occurred outside the hospital setting (Martin et al. 2012, 9).<sup>2</sup> However, according to the CDC, between 2004 and 2009, the rate of home births alone, not including birth center and other OOH births, increased by 29 percent nationwide. Amongst non-Hispanic white women, the increase was 36 percent. This means that in 2009, about one out of every ninety births to non-Hispanic white women was a home

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<sup>1</sup> While Alaska has the highest rate of total out-of-hospital birth, Montana and Oregon both have higher rates of home birth (Martin et al. 2012, 9).

<sup>2</sup> Of these, 67 percent took place in a residence and 28 percent took place in a freestanding birth center.



birth (MacDorman, Mathews, and Declercq 2012, 2). The statistics also show that the rate of OOH birth rises with increasing birth order and maternal age (MacDorman, Mathews, and Declercq 2012, 4), meaning women now increasingly choose OOH birth as they become older and more experienced. In order to understand the growing trend of OOH birth, it is essential to examine the context in which it is taking place.

## 1.2 Controversy in American Maternity Care

Over the past half-century, attitudes surrounding childbirth have changed dramatically. In 1969, the *Better Homes and Gardens Baby Book* advised pregnant women:

Don't worry if a friend's doctor has recommended something different for her than your physician has for you. Your doctor knows your case best and has your welfare in mind. He has reasons for whatever instructions he has given you. Don't compare notes with other pregnant women, or veteran mothers. This only causes worry (*Better Homes and Gardens Baby Book* 1969, 41).

Thirty-six years later the discourse had taken on a decidedly different tone, as written by a doctor and former director of the World Health Organization:

The gap between actual obstetric practices in the United States and what scientific evidence indicates obstetric practice should be continues and will be slow to change until there is sufficient pressure—from women, scientists, politicians, and the media—to force more evidence-based practices (Wagner 2006, 69).

In 1900, almost all births in the United States took place outside the hospital setting. By 1940, this was true of only 44 percent of births. By 1969, less than 1 percent of babies were born outside the hospital setting (MacDorman,

Mathews, and Declercq 2012, 1). In 2010, 98.8 percent of all U.S. births took place in the hospital, with 87.3 percent attended by medical doctors and 7.7 percent attended by Certified Nurse-Midwives (Martin et al. 2012, 9). The United States is unique in its proportion of obstetricians to midwives. In many other countries, midwives are an integral part of mainstream medical care. In the Netherlands, Great Britain, Australia, New Zealand, Germany, Ireland, and all the Scandinavian countries, more than 75 percent of all births are attended by midwives (Wagner 2006, 5).<sup>3</sup>

Between 1900 and 1969, birth in the U.S. moved from being predominantly OOH to taking place almost exclusively in the hospital. Between 1968 and 1977 the cesarean rate tripled. The National Institute of Child Health and Human Development convened a conference in order to gain a scientific and professional consensus about the increase in cesareans and concluded that the trend could be stopped and reversed with no adverse effects on outcomes using methods that included vaginal birth after cesarean (Rooks 1997, 93-94). However, the cesarean rate never returned to the recommended level. Between 1996 and 2009, the national cesarean rate increased by 56 percent, bringing it to a record high of 32.9 percent (Hamilton, Martin, and Ventura 2012, 2).<sup>4</sup> In the context of certain obstetrical complications, cesarean birth is a life-saving measure. However, when not medically necessary, cesarean birth increases the risk of respiratory problems for the infant, the risk of mortality for the mother, and also the risk for complications in the mother's subsequent pregnancies (Johnson 2011; Rooks 1997, 94-95; Wagner 2006, 37-69). There is evidence that the enormous increase in the cesarean rate over the past several decades was

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<sup>3</sup> For a comparative study of American and Canadian midwifery models see Robbie Davis-Floyd and Christine Barbara Johnson's, *Mainstreaming Midwives: The Politics of Change*. Routledge, New York, 2006.

<sup>4</sup> From 1996 to 2007, Alaska's cesarean rate rose from 16.7 percent to 22.6 percent, an increase of only 35 percent compared to the national increase of 53 percent (Menakcer and Hamilton 2010, 5).

driven largely by concerns related to liability, profit, and convenience rather than medical necessity (Daviss 1997; Johnson 2010; Wagner 2006, 38-39, 154).

In recent years, evidence has arisen calling many obstetric interventions into question. It has been shown that routine use of Electronic Fetal Monitoring (EFM) does not improve outcomes and does increase the cesarean rate unnecessarily (Banta 2002; Devane et al. 2012; Haverkamp et al. 1976; Rooks 1997, 314-315). The drug Misoprostol, which is marketed as Cytotec, was approved by the Food and Drug Administration (FDA) for treating stomach ulcers but is commonly used for labor induction. This use is contraindicated. Use of Cytotec for induction has been linked to uterine rupture, which can lead to death of the baby and also the mother (Food and Drug Administration 2009; Wagner 2003). Even seemingly simple procedures like routine amniotomy (breaking the water) and immediate umbilical cord clamping are being challenged (Andersson et al. 2011; Hutton and Hassan 2007; Smyth, Alldred, and Markham 2013).

In 1998, the CDC issued a press release reporting that, “[a]fter controlling for a wide variety of social and medical risk factors, the risk of experiencing an infant death was 19 percent lower for births attended by Certified Nurse-Midwives than for births attended by physicians” (for an explanation of the CPM credential see section 3.2; National Center for Health Statistics, 1998). The study also found that the risk of death in the first twenty-eight days of life was 33 percent lower with a Certified Nurse-Midwife. The risk of giving birth to an infant with low birth weight was 31 percent lower, which is significant because low birth weight is a major predictor of infant mortality, subsequent disease, or developmental disabilities. While physicians attended more births involving medical complications, Certified Nurse-Midwives attended a higher proportion of women with socio-demographic risk factors for poor birth outcomes. The press release concludes:

However, birth outcomes for certified nurse midwives were better even after socio-demographic and medical risk factors were

controlled for in statistical analyses. The differences in birth outcomes by certified nurse midwives and physician-attended births may be explained in part by differences in prenatal, labor, and delivery care practices (National Center for Health Statistics, 1998).

While serious concerns have been raised about maternity practices, the standard of care has been slow to change. Maternal mortality has been increasing for more than twenty years (Amnesty International 2010, 1; Wagner 2006, 162). The CDC's preliminary data for 2011 shows that the cesarean rate remains at 32.8 percent (Hamilton, Martin, and Ventura 2012, 2). The *CIA World Factbook* ranks the U.S. at number fifty-one for infant mortality, with six deaths per thousand live births (*CIA World Factbook*, 2012). In terms of maternal mortality, the U.S. is tied with Hungary and Iran for forty-seventh place, with twenty-one deaths per hundred thousand live births (*CIA World Factbook* 2010). The United States spends more than any other country in the world on healthcare (Amnesty International 2010, 1; *CIA World Factbook* 2009). The term "iatrogenic" has come into use to discuss problems that are "inadvertent effects of medical treatment" (Rooks 1997, 296). The term "birth rape" has also come into use to describe the treatment that some women have experienced during childbirth (Freeze 2008, 104).

While debate has been increasing about obstetrical practices, studies have also been coming out regarding the safety of midwifery care. In 2005, Daviss and Johnson published a study of all planned home births attended by a Certified Professional Midwife (CPM) in the U.S. and Canada in 2000 (for an explanation of the CPM credential see section 3.2). The study included 5,418 women planning to give birth at home when labor began. The outcome was 12.1 percent hospital transfers, 3.7 percent cesarean sections, 1.7 percent infant mortality, and zero maternal deaths (Daviss and Johnson, 2005, 1).

In 2013, the American Association of Birth Centers published a study of 15,574 low-risk women at seventy-nine freestanding birth centers across thirty-

three states between 2007 and 2010 (for a definition of “birth center,” see section 3.2). 94 percent of these women achieved a vaginal birth. The cesarean rate for these women was 6 percent while the national rate of cesarean birth for low-risk women is 27 percent. The transfer rate was 13.9 percent. The rate of stillbirth was .047 percent and neonatal mortality was .04 percent (Daviss and Johnson 2005, 1).

These and many other studies have shown that midwifery and OOH care can be viable and safe alternatives to obstetrician-attended hospital birth; however the issue remains controversial. In 2003, the World Health Organization published a training module called “Essential Antenatal, Perinatal, and Postpartum Care.” In it the authors acknowledge that the last century has seen astonishing improvements in maternity care overall; however, they find that maternity care is not what it should be. The World Health Organization states:

Many professionals initially believed that malice, hard-line feminist dogma, mischief, or other nonspecific unworthy motives inspired these types of criticism. But such a defense is no longer credible – if indeed it ever was. The fact is that all over the world maternity care has been weighed in the balance and found wanting, and the process continues. Despite the recent emphasis on evidence-based medicine in many countries, we find in the late 1990s that there are countries where Cesarean section rates are rising to absurdly high levels (in many cases over 50%), even though those societies have access to modern information and facilities. . .

.[P]regnancy is not an illness. It is, therefore, extraordinary that for so long in this century a bizarre belief that the management of pregnancy should proceed along medical lines has been held to be above question. We can now see that this error has led us to create medically based systems to care for a predominantly nonmedical

situation. These systems can – and frequently do – act against the best interests of mothers and babies (WHO 2003, 9-10).

Marsden Wagner is a perinatologist-neonatologist and the former Director of Women's and Children's Health for the World Health Organization. In 2006, he published a book entitled, *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First*. Having many years of experience in the field, he articulates very well the complexity and the systemic nature of the issue. Wagner explains the term "cascade of interventions:"

In the past decade, the classic example of such a cascade is an induction of labor with powerful drugs, which leads to increased labor pain, which leads to an epidural block to relieve the pain, which leads to a slowing of labor, which becomes 'failure to progress,' the number one diagnosis used to justify pulling the baby out with forceps or a vacuum extractor or performing a C-section (2006, 39-40).

Wagner notes that these interventions are understandable from the standpoint that obstetricians are highly trained surgeons. Their education focuses on pathology and surgery. He compares them to fish who cannot see the water in which they swim, writing: "Most obstetricians have experienced only hospital-based birth managed within a medical model. They have never seen natural birth. So they cannot see the profound effect their interventions are having on the entire process" (2006, 40). Wagner explains that many obstetricians operate with "blind faith" in technology, equating technology and intervention with progress and modernity (2006, 40). He cites several examples in which doctors use tools and practices that are not supported by scientific evidence. Wagner examines in depth the legal and cultural reasons behind this apparent contradiction.

In 1992, University of Texas cultural anthropologist Robbie Davis-Floyd examined a similar question in her book, *Birth as an American Rite of Passage*. In it, she asks how a discipline that presents itself as scientific can appear so

irrational as evidence accumulates about the “unnecessary and often harmful nature of obstetrical procedures” (Davis-Floyd 2003, 2). Davis-Floyd writes that these procedures:

are in fact rational ritual responses to our technocratic society’s extreme fear of the natural processes on which it still depends for its continued existence. Cumulatively, routine obstetrical procedures such as intravenous feeding, electronic monitoring, and episiotomy are felt by those who perform them to transform the unpredictable and uncontrollable natural process of birth into a relatively predictable and controllable technological phenomenon that reinforces American society’s most fundamental beliefs about the superiority of technology over nature (Davis-Floyd 2003, 2).

As the above examples demonstrate, even the framing of birth as a strictly biomedical event is a cultural construct. If culture is a significant factor in any model of care, then in order to understand birth practices, they must be studied in a way that incorporates the culture of the participants.

### 1.3 Pregnancy and Birth at AFH&BC as a Rite of Passage: Research Questions, Hypothesis, and Analysis

How do the midwives at AFH&BC help their clients to navigate the process of pregnancy, birth, and the postpartum period with such a high rate of success, as defined by a low cesarean rate, low mortality and morbidity, and high maternal satisfaction? Specifically, how do the midwives prepare mothers to navigate the transformative process of pregnancy, birth, and the postpartum period and how do the midwives address failure to progress during birth?

The answers to these questions depend upon how birth is understood. This study analyzes birth as a rite of passage. The rite of passage concept is a useful framework for analysis in this case because it incorporates both a culture’s worldview and its practices.

French ethnographer and folklorist Arnold Van Gennep defined rites of passage as having three phases: separation, transition, and reintegration (Van Gennep 2004 [1960]<sup>5</sup>). Pregnancy, birth, and the postpartum period naturally fall into these three phases, although this is more a result of the physiological process than of ritual actions. Therefore, this thesis focuses primarily on pregnancy and birth as a 'passage,' marked by both a social and a physiological transformation (for example, from non-mother(hood) to mother(hood), from pregnant woman to parturient to postpartum woman).

If the transformation itself is naturally occurring, the human actions that ritualize this passage are a culture's response to this change. This response reflects and transmits the worldview of the culture and orients the initiate to her new position in society. The ritual is an ordering mechanism which integrates what would otherwise be a disruptive change. At AFH&BC, the process of birth is viewed as a normal part of life.

This thesis argues that the midwives at AFH&BC help their clients to navigate the process of pregnancy, birth, and the postpartum period by employing a positive, holistic view of the natural, physiological process, by applying this view in practices that support the physiological process and minimize intervention, and by keeping the space in which OOH birth takes place. The fact that parents and practitioners are choosing an alternative ritual for maternity care at an increasing rate nationwide reflects a change happening in American culture at large.

## 1.4 Rites of Passage

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<sup>5</sup> The first publication of the English edition was in 1960, the first version was published in French in 1909.



In order to undertake this analysis, it is necessary to define a rite of passage. In 1909, Arnold Van Gennep wrote a book which was later published in English entitled *Rites of Passage*. In it he categorized rites of passage and included two chapters on pregnancy, birth, and childhood (2004, 41-64). His work drew upon ethnographic data from many different cultures. While the ceremonies themselves varied widely, Van Gennep found an organizing principle that explained similarities in the rites. He proposed that rites of passage have a “tripartite” structure that moves the initiate through three stages: separation, transition, and reintegration (2004, 44). The following examples demonstrate the tripartite structure of the rituals surrounding pregnancy and birth.

Van Gennep describes a practice among the Todas of India (2004, 42-43). When a woman becomes pregnant, she is forbidden to enter the villages or sacred places. At five months gestation, she goes to live briefly in a special hut and is ritually separated from the dairy, which is the focal point of social life in the Toda culture. Ceremonies are performed and then she returns to her own house before the seventh month. When the child is born, “The woman is delivered in her house, in anyone’s presence, and without special ceremonies” (2004, 42). Two or three days following the birth, mother and child leave again to live in a special hut, with the same ceremonies preceding their return home.

Van Gennep also describes Bulgarian rites (2004, 45). During the ninth month the mother must not leave her home. She must wear the clothing for the birth for a week without removing it. After the birth, a fire is kept burning until the time of christening. Cakes are baked and the young mother takes the first bite, then shares the cake with her relatives. All of the cake must stay within the house. The relatives bring gifts and spit upon the mother and child, integrating them into the community. Throughout the first week relatives come to visit the mother and child and then on the eighth day the child is baptized. On the fifteenth day the mother bakes cakes. Neighbors and friends come to eat cake and each brings the family flour.

Van Gennep also cites the Hopi of Oraibi in Arizona (2004, 43-44). The mother gives birth at home with her own mother attending during labor. However, neither she nor anybody else is allowed to attend the delivery itself. Only the mother and baby are together at the moment of birth. The grandmother returns, if needed, to assist with the delivery of the placenta and to tie the umbilical cord. There are dietary taboos for the mother for the first twenty days after the birth. If this was her first pregnancy, she is not allowed to leave her house before sundown for these days. If this was not her first pregnancy then she only has to obey this rule for the first five days following birth. The mother and child are ritually bathed on the fifth, tenth, and fifteenth days after the birth. On the twentieth day the woman, her baby, her husband, her mother, and other relatives are bathed in the same way. On that day the mother can name her child and the child is then presented to the sun. The community shares a meal and life returns to normal.

Van Gennep states that at the time of his writing, rites of separation at pregnancy and birth had been studied by anthropologists more than rites of reintegration or transition (2004, 41). As men in 1909, Van Gennep and the sources upon which he relied may not have had much access to information about the birthing process itself. Van Gennep also makes it clear that he was more interested in the “magico-religious” aspects of ritual than the “mundane” details of less exotic practices (2004, 47). As a folklorist, he focused on the rite, rather than the passage itself.

In 1969, Victor Turner published a book entitled *The Ritual Process: Structure and Anti-Structure*. In it, Turner accepted Van Gennep’s tripartite model and focused his work on the liminal phase during which the transition takes place. Basing his theory primarily on ethnographic data from Africa, and specifically on male initiation rites into manhood, Turner developed a concept about social status and relationships during this liminal period which he called “*communitas*.” Turner describes how initiates are temporarily stripped of their

normal social roles and status. During the liminal period when all the boys go out to live in the bush together, they are all equals. A chief's son is the same as a slave and all must follow the ritual elder's orders exactly. Turner called this period without status "anti-structure," juxtaposed against the normal organization of social roles and relationships, which he called "structure." Turner writes:

It is as though there are here two major 'models' for human interrelatedness, juxtaposed and alternating. The first is of a society as a structured, differentiated, and often hierarchical system of politico-legal-economic positions with many types of evaluation, separating men in terms of 'more' or 'less.' The second, which emerges recognizably in the liminal period, is of society as an unstructured or rudimentarily structured and relatively undifferentiated *comitatus*, community, or even communion of equal individuals who submit together to the general authority of the ritual elders. I prefer the Latin term '*communitas*' to 'community,' to distinguish this modality of social relationship from 'an area of common living' (1969, 96).

Turner suggests that humans have an "indispensable human social requirement" for "exposure to or immersion in *communitas*" and that *communitas* is a common thread in all cultures as expressed through religion, art, and philosophy (1974, 99). He states that the process of "leveling" or "stripping" initiates of their social status is referred to as sacred in many cultures. Individuals stand before each other not divided into the roles that each man plays, but in their complete totality, "men in their wholeness wholly attending" (1969, 128). The removal of social status that is characteristic of *communitas* yields experiences of extreme potency that often "flood their subjects with affect," opening initiates to receive the knowledge transmitted during the ritual (1969, 128).

While Turner states that *communitas*, or anti-structure, is an inherent human impulse, he also notes that it is not self-sustaining. Turner observes that a

great deal of structure is required in order to maintain the lack of differentiation between individuals. Efforts to build communities around the notion of *communitas* usually end in strict oppression. Rather than choosing between structure or anti-structure, Turner suggests that there is an ongoing dialectical process between the two, through which individuals progress to different social states. Turner concludes that,

for individuals and groups, social life is a type of dialectical process that involves successive experience of high and low, *communitas* and structure, homogeneity and differentiation, equality and inequality. The passage from lower to higher status is through a limbo of statuslessness. In such a process, the opposites, as it were, constitute one another and are mutually indispensable (1969, 97).

Structure is the normal state of society and *communitas* inherently challenges the status quo. “[F]rom the standpoint of structural man, he who is in *communitas* is an exile or a stranger, someone who, by his very existence, calls into question the whole normative order” (1974, 100). As such, *communitas* is normally found in the interstices and on the periphery of institutions, on the margins of culture, amongst the structurally inferior, in counterculture, and during the liminal phase. However, Turner adds that during times of change, *communitas* becomes more important as old roles fall away and new ones are formed. “[I]n times of drastic and sustained social change, it is *communitas* which often appears to be central and structure which constitutes the ‘square’ or ‘straight’ periphery” (1974, 100). As formulated by Turner, *communitas* is a creative force in social change.

Liminality, marginality, and structural inferiority are conditions in which are frequently generated myths, symbols, rituals, philosophical systems, and works of art. These cultural forms provide men with a set of templates or models which are, at one

level, periodical reclassifications of reality and man's relationship to society, nature, and culture (1969, 128-129).

Turner advanced Van Gennep's tripartite model of rites of passage primarily by expanding the concept of the liminal stage and identifying the dialectic between structure and anti-structure. He called the period of anti-structure "communitas," a more or less egalitarian period of statuslessness that happens during the transition from one social state to another. While Van Gennep focused on the whole tripartite structure and the rites rather than the passage, Turner focused on the social status of initiates during the liminal phase. Turner noted that communitas is a state that cannot, and should not necessarily be maintained, even though it has many times been idealized. Instead, he posed structure and anti-structure as a dialectical process through which individuals move as their life-cycle naturally progresses.

When Robbie Davis-Floyd published *Birth as an American Rite of Passage* in 1992,<sup>6</sup> it was mainstream maternity care—mainly obstetrics—that was analyzed as a rite of passage. In this book Davis-Floyd thoroughly examines maternity care during all phases of Van Gennep's tripartite structure. She examines the entire process of separation, liminality, and reintegration as it relates to childbirth. She focuses on the rites performed by medical doctors with mothers as initiates, and shows that birth is a rite of passage not just because it physically and socially transforms the woman into a mother but also because during this passage the rites surrounding pregnancy and birth reflect and transmit the culture's most deeply held beliefs. "The core values and beliefs of both individual women and the wider society in which they live condense into visible, focused form in childbirth" (2003, 307). In a way reminiscent of Turner, Davis-Floyd noted that the *affectivity* of birth is not so much created by the doctors as it is a result of the birth *process*.

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<sup>6</sup> A second edition of *Birth as an American Rite of Passage* was published in 2003.

Davis-Floyd found that the mother's perception of the birth afterward reflects "the degree to which this experience confirms or undermines the belief system with which she enters the hospital" (2003, 306). Most of the women she interviewed preferred to give birth in a hospital (2003, 281). While Davis-Floyd examines birth primarily as an individual rite of passage, she also discusses how a rite of passage is an opportunity for social change:

Paradoxically, ritual, with all of its insistence on continuity and order, can be an important factor not only in individual transformation but also in social change (Geertz, 1957; Turner 1969, 1974). New belief and value systems are most effectively spread through new rituals designed to enact and transmit them. Even if a ritual is being performed for the very first time, 'its stylistic rigidities and its internal repetitions of form or content make it tradition-like' (Moore and Myerhoff 1977:9), thus giving entirely new belief systems the feel and flavor of being strongly entrenched and sanctioned by ancient tradition. Moreover, entrenched belief and value systems are most effectively altered through alterations in the rituals that enact them. Indeed, ritual represents one of society's greatest potentials for the kind of revitalization that comes from internal growth and change in response to changing circumstances (Wallace 1966) [Davis-Floyd 2003, 17].<sup>7</sup>

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<sup>7</sup> Geertz, Clifford. 1957. Ritual and social change: A Javanese example. *American Anthropologist* 59 (32-54);  
 Moore, Sally Falk and Barbara Meyerhoff, eds. 1977. *Secular Ritual*. Assen, The Netherlands: Van Gorcum.  
 Turner, Victor. 1969. *The ritual process: Structure and anti-structure*. Chicago: Aldine Press.  
 Turner, Victor. 1974. *Dramas, fields, and metaphors: symbolic action in human society*. Ithaca, New York: Cornell University Press.  
 Wallace, Anthony F. C. 1966. *Religion: An anthropological view*. New York: Random House.

Davis-Floyd concludes by noting that, “as individuals within a society shape birth, so shall they shape social life” and expresses hope that birth will become an avenue for social change (2003, 307).

The process of birth at AFH&BC also corresponds to the tripartite model established by Arnold Van Gennep. Long before a woman’s pregnancy is visible, her life begins to change. Often the first sign is the cessation of her menstrual cycle.<sup>8</sup> Swollen and sore breasts are also an early sign of pregnancy. Increased hormone levels make her extremely tired for the first trimester. Many women also experience morning sickness, which can take place at any time of the day or night. This is coupled with a heightened sense of smell that can add to her nausea and repel her from foods and environments that she previously enjoyed. The woman is encouraged to abstain from alcohol, smoking, coffee, soft cheeses, and sandwich meats, as well as to limit her intake of tuna because all of these can have harmful effects on the fetus. Increased hormone levels also result in uncharacteristically emotional behavior. Most women see a doctor or midwife to confirm the pregnancy and begin prenatal care.

By the beginning of the second trimester, most of the danger of miscarriage has passed and the child is likely to survive. His or her heartbeat becomes audible and soon the mother can feel the baby moving within. Morning sickness and fatigue usually subside by the second trimester. However, the woman’s mobility is increasingly affected. Many women experience trouble walking and back pain in the third trimester. Even women who stay active do not usually maintain the same range of physical activities in which they may have participated before they were pregnant. The pressure on the mother’s bladder increases, causing her to urinate very frequently, making proximity to a restroom a factor in her daily life. Clothing issues become more and more pronounced. She can no longer wear any of the clothes from before her pregnancy. She has

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<sup>8</sup> A very small percentage of women have very heavy implantation bleeding that they mistake for a menstrual cycle. An even smaller number actually continue to bleed as if menstruating while pregnant.

gained weight both from the baby and on her own body, changing her outward appearance. Her own body is changing rapidly without her conscious effort. Her pregnancy shows visibly, making all who see her aware of the child growing within. This is now an obvious part of her identity in society, regardless of how the mother perceives herself.

All of these physiological changes serve gradually to separate a woman from her previous non-pregnant state. These physical changes are met with a wide variety of reactions from the society around her. While at AFH&BC these changes and the reactions to them are neither homogenous nor ritualized in the same way described by Van Gennep, they achieve the social and spatial separation that Van Gennep describes. As this thesis seeks to demonstrate, these changes may be analyzed as the first, separative phase of the rite of passage.

Following the birth, the mother's hormones change markedly. Her sleep cycle is disrupted as the newborn adjusts to life outside the womb and to eating rather than receiving nutrients through the umbilical cord. The uterus slowly tightens back to its normal size and restores the area where the placenta was attached to the uterine wall. There is risk of infection during this time. The mother's breasts engorge as her milk comes in two to three days after the birth. The body continues to have bleeding and discharge for a month to six weeks and high levels of activity can lengthen the time needed for recovery. The woman's body does not return immediately to its pre-pregnant shape. Her pre-pregnant clothes do not fit immediately following the birth. The newborn requires a great deal of the mother's attention, reducing her ability to participate in other endeavors and/or requiring a significant amount of assistance.

Just as before the birth, afterwards there is a period during which the mother's mobility, appearance, hormones, and identity are affected. The return to the non-pregnant state is gradual and may be analyzed in light of Van Gennep's period of reintegration that concludes the tripartite model for rites of passage.



Following Van Gennep's and more specifically Turner's theoretical contribution, this ethnography focuses on the liminal stage of the rite of passage during which the transformation takes place. I argue that this period begins at the start of prenatal care and ends after the birth, either when the mother and child leave the birth center or when the midwives leave the family's home. This thesis examines the "anti-structural tendencies" in the culture of the AFH&BC, and how those tendencies simultaneously reflect and contribute to social change in the broader culture. It is important to note that birth is a significant rite of passage not only for the mother, but for the baby and the father as well (and to a lesser extent for the siblings (if any) and for more distant kin. This study, however, focuses on mothers and on the transformative process of becoming a mother.

This ethnography fills multiple gaps in the existing literature. First, it provides a bridge between statistical evidence and stories shared informally from woman to woman. Second, this study focuses on Alaska. While Alaska has the highest rate of OOH birth in the country, little literature about birth practices in Alaska, past or present, has been published. Lastly, this thesis provides insight into the nationwide trend toward OOH birth, suggesting that it reflects a change happening in the dominant worldview of the U.S.

### 1.5 Methods and Methodology

This study was approved by the Institutional Review Board (IRB) at the University of Alaska Fairbanks on September 16, 2011 (Project # 237284-4). Approval was preceded by nine months of research into the literature.

While the North, and specifically urban Alaska, provide the context for this study, cultural anthropology provides the disciplinary basis. The main data collection methods were interviews and participant observation. Ethnography is the ideal discipline to capture this type of data. This is not a biomedical study. This project seeks to remedy a gap in the existing literature between biomedical research and anecdotal accounts of childbirth.

Interviews were conducted in the fall of 2011 and early winter of 2012. The questions were open ended so that the interviewee could insert other topics if desired. Efforts were made to distribute interview questions to participants in advance so they would have time to consider their responses before the interviews.

Methodologically, interviewing is very useful because several respondents can be asked the same questions. Interviews can be used to confirm or clarify data gathered through participant observation. It also can reduce the need for interpretation by the researcher because responses are given in the interviewee's own words and can be video- or audio-recorded so that quotations may be used.

Participant observation is also a key method of this study because it provides access to a more holistic understanding of the field. A holistic understanding requires engaging in the action and experiencing the sights, sounds, and smells of the field. It requires witnessing the interaction between midwives and families, both verbal and non-verbal. This technique can capture unconscious responses and behaviors that participants do not realize are unique, or that they do not consider important and hence would not mention in an interview. These elements of the birth process are not easily captured in a survey. Participant observation gives access to a level of insight and intimacy that would not be available through respondents' descriptions only.

Why are the ethnographic method and the holistic approach the best tools for this study? As Claire stated in her interview: "These questions are good. You're not a uterus, you're a whole person" (Taylor 2011). It will become clear in the following chapters that the care provided at AFH&BC is of a holistic nature. Factors like emotions, trust, and personal interaction play significant roles in the birthing process. Without holistically oriented field methods, it would be impossible to measure fully the care being provided. The picture probably would

be incomplete, incomprehensible, and not representative of the participants' views and practices.

Using interviews and participant observation allows the researcher to crosscheck information and identify common themes, giving the results greater accuracy. Following the same narrative arc of pregnancy and birth with several different women, in the same setting, also bolsters validity. Kathleen and Billie DeWalt explain the value of such multiple observations:

Another way to test the reliability of observations is to carry out several at much the same time. This is commonly done by researchers who attempt to observe or participate repeatedly in similar events over the course of fieldwork, or to discuss the same issues with a number of different informants (2002, 95).

Participants for this study were recruited by flyers posted at the birth center and, ultimately, by word of mouth. All of the midwives at the birth center participated in the study (except for the midwives who joined AFH&BC after the data collection period). All names have been changed for privacy, although for people who know the participants the details will inevitably be recognizable.

Only voluntary participants were used in this study. The relatively small sample size of ten participants may not be a perfectly representative sample of the whole AFH&BC birth culture. However, the generalized perspectives of the midwives are juxtaposed with the individual perspectives of the mothers. National statistics and literature provide context for these individual accounts. Interviews were each one and a half hours long or more, allowing for depth of conversation. A total of ten participants, including four midwives and six mothers, contributed to the data.

During the data collection phase, as the researcher, I was pregnant and used AFH&BC for prenatal care and birth. Obviously, this gave me unique insight and access to this particular birth culture. I had the opportunity to see and hear

many people's opinions, including those who had never heard of AFH&BC, those who would never use it, and one who was choosing not to use it again. All the unsolicited advice that pregnancy notoriously attracts suddenly became fascinating.

It could be argued that having been pregnant during the study undermined my objectivity as an observer. Rixa Ann Spencer Freeze was in a similar position with respect to her dissertation on unassisted childbirth in the U.S. She wrote very eloquently on the matter:

Birth is not something that I think about only during school hours or that I put away, mentally, at the end of the day. That is my greatest strength and potentially my biggest weakness. Childbirth is difficult for almost anyone to remain neutral about, because it is such a personal, intimate, life-altering event. Choices that go against the mainstream are particularly controversial and divisive. I anticipate that I will be challenged for not being "objective" enough with this project, since I am an advocate and participant as well as a researcher. Critics might argue that I will inevitably be biased towards my subject matter and that I will be unable to escape from mere boosterism. I do not claim to be an "objective" researcher, nor do I try to be. . . . I would argue that it is impossible to take a dispassionate, unengaged approach to childbirth (Freeze 2008, 27).

Rather than undermining this study, being pregnant and giving birth at AFH&BC during the course of this study could also be seen as an "enhanced" form of participant observation, thereby adding legitimacy to the findings. This study would not be the same without direct experience of pregnancy and birth at AFH&BC. The controversial history of American maternity care demonstrates the importance of researchers from within the field. As a discipline, anthropology has been criticized for the imperialistic aspects of research practices, particularly in

conjunction with minority populations and feminist issues (Smith 1999). Insider and community-based research are increasingly favored and there is ample discussion on this issue in academic discourse (Freeze 2008; Mihesuah 1998; Stoecker 2005). This study is not a description of my own personal experience at the Alaska Family Health & Birth Center. While my own pregnancy and birth have offered valuable insight, applying the ethnographic and analytical tools from my academic training has allowed me to analyze this topic far beyond my own experience.

### 1.6 Execution of Research

Initially, the plan was to interview each participant before and after the birth, attend one prenatal appointment, and if possible, also attend the birth. The Institutional Review Board (IRB) concluded that attending the birth posed too great a risk of infection, so that part of the study was abandoned.

Thirteen interviews with four midwives and six mothers took place between October 2011 and February 2012. All interviews were video-recorded and will be stored for five years in the office of Patrick Plattet at the University of Alaska Fairbanks Anthropology Department, as per IRB requirements.

Fieldwork at the birth center also included attending the AFH&BC birth preparation class, two annual AFH&BC fundraisers, one postpartum support meeting, one prenatal appointment, and one neonatal transport. Additionally, fieldwork outside the birth center included multiple visits to the maternity ward at Fairbanks Memorial Hospital, and the Midwives Association of Alaska annual conference in August and September 2011 where Robbie Davis-Floyd was the keynote speaker.

### 1.7 Chapter Summaries

Chapter one of the thesis introduces the Alaska Family Health & Birth Center, OOH birth, and controversies in American maternity care. It then

presents the research questions, hypothesis, and framework for analysis. The methods and methodology used for data collection are explained. Chapter two describes the Alaskan context and Alaska Native birthing traditions. Chapter three presents the context of midwifery care at AFH&BC, including the midwifery model of care, the different types of birth attendants, the legal framework for the practice of midwifery in Alaska, and statistics from AFH&BC. The participants involved in the study are introduced, including what brought them to AFH&BC. Chapter four explores prenatal care and preparation for birth at AFH&BC. Chapter five examines intrapartum care—the birth itself. This chapter relies on birth stories from the mothers who participated in this study. Chapter six examines the physiological process of birth with a focus on the holistic understanding employed by AFH&BC. Chapter seven discusses how AFH&BC midwives address failure to progress. Chapter eight follows one of the mothers through the cesarean birth of her daughter and examines the relationship between AFH&BC and Fairbanks Memorial Hospital. Chapter nine addresses the role of midwives as “keepers of the space.” Chapter ten concludes with a summary the findings.

## Chapter 2: The Alaska Context

### 2.1 Geography, Environment, and Culture

Alaska is a unique setting for birth in many ways. Geography, history, and culture have had significant impacts upon birthing practices in the state over time.

Alaska is remote. Not only is the state physically removed from the rest of the country, distances within the state are vast. Currently, most of the state's population lives in the three urban centers: Anchorage, Fairbanks, and Juneau.<sup>9</sup> Glaciers, mountains, and vast forests render much of the state inaccessible. The weather is as forbidding as the terrain, making it a factor in everyday decision-making. Many parts of the state, including the capital, Juneau, are not accessible by road. They can only be reached by boat or plane. Alaska covers an area equal to 20 percent of the continental United States, and yet, at 710,231 people, the entire population of Alaska is a fraction of that found in most major US cities (Alaska Department of Labor and Workforce Development 2011, 1).

As a result of these conditions, if a mother lives in rural Alaska, she has to travel at thirty-six weeks of gestation in order to be near a hospital for her delivery. Before that time, specialized medical care cannot be reached except by "med-evac" (an emergency medical evacuation flight). In some villages, modern technology has made it possible for community health aides to call a hospital and have a video-conference in the village birthing room. Where the technology is in place, doctors in Anchorage have control over a camera that they can move all around the remote birthing room, zooming in and out, so that they may give advice to community health aides. Nevertheless, if a woman decides to stay amongst her loved ones and give birth in her own village, she does so knowing that certain medical services will not be available to her and her baby.

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<sup>9</sup> Each of these cities currently has at least one birth center.

## 2.2 Costs and Insurance

Travel within the state is very expensive. However, in the 1960s, oil was discovered at Prudhoe Bay on the North Slope of the Brooks Range. Royalties from oil sales have made the state wealthy. The state Medicaid program is available for all women under a certain income level. This program, called Denali KidCare (DKC), pays for all prenatal care and birth expenses, as well as all expenses for traveling to a major city and staying there until the birth. It is a tremendously comprehensive program. It will pay for a hospital birth or a birth with AFH&BC. DKC plays an enormous role in the birth culture of the state and was cited by two of the mothers as a factor in their access to care. Denali KidCare is available to all Alaskans based on income, regardless of culture or ethnicity. Meanwhile, all Alaska Natives have free health insurance through the Indian Health Service.<sup>10</sup> While private insurance does not cover midwifery care in many other states, it does in Alaska. Sienna cited this as a reason why it was possible for her to use AFH&BC. Across the nation, online forums often discuss issues surrounding access to midwifery care, and insurance is frequently cited as a reason why women cannot seek OOH or midwifery care, even when they would prefer it. For clients who are not insured, AFH&BC also accepts cash payments.

The financial agreement signed by parents at the beginning of care states that the average birth with AFH&BC costs \$7,000 from prenatal care through postpartum. Included in the \$7,000 average cost is a facility fee. The facility fee at AFH&BC is \$2,200; therefore a home birth can be considerably less

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<sup>10</sup> Eligibility for coverage by the Indian Health Service (IHS) is generally determined by the applicant's enrollment in a Federally recognized tribe, of which Alaska has 228. A woman pregnant with the child of a man who is eligible for IHS coverage is also eligible for coverage during her pregnancy and postpartum period (Indian Health Service website "FAQ," accessed February 12, 2013; Indian Health Service website, "Alaska Area," accessed February 12, 2013.)



expensive.<sup>11</sup> The final cost depends on the length of prenatal visits, the amount of testing performed, etc. Clients are responsible for any expenses incurred in the case of a hospital transport.

### 2.3 Alaska Native Birthing Traditions

Midwives represent a body of knowledge that goes back hundreds of generations. Theresa Arevgaq John, is a Yup'ik elder and Assistant Professor in the department of Cross-Cultural Studies (formerly of the Alaska Native Studies and Rural Development) at the University of Alaska Fairbanks. Theresa was born in the summer at her family's fish camp on Nelson Island. Her grandmother was a midwife who delivered many babies for the women of her village, although Theresa said her grandmother did not deliver her. Theresa's work is representative of a growing interest in documenting and revitalizing indigenous cultures, and she kindly agreed to share what she knew about the traditional midwifery practices in an interview that took place in her office in November 2011 (John 2011).

In general, Alaska Native midwives observed the pregnant women very closely and monitored their progress. Unlike doctors in far away hospitals, the midwives were able to observe the entire pregnancy leading up to the birth. They were familiar with the woman's health, behavior, and disposition prior to pregnancy. They provided one-on-one care and maintained a very close connection with the mother-to-be. Cesarean births were not practiced in traditional culture so prenatal and preventative care was very important.

The midwife paid special attention to the shape of the woman's belly as it developed. Sometimes babies had to be flipped prior to birth if they were in the breech position (head up). To this day fetal malposition remains one of the most common complications in birth. Traditional midwives knew how to assess the

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<sup>11</sup> For comparison, an independent homebirth midwife usually charges from \$1,500-\$3,000 for prenatal care and birth (Scott 2012). A cesarean section can cost \$15,000 or more.

baby's position by looking and touching, as well as knowing techniques to help change the position if needed.

The steam bath was an important part of prenatal care. The pregnant mother would sit in a lower, cooler spot and the other women would massage her, sometimes using little branches to stimulate blood flow to her belly and the baby.

Prenatal care also included making sure that the mother was eating nutritious food and getting plenty of exercise. Laziness is considered a very bad trait in Alaska Native cultures, whether a person is pregnant or not. During pregnancy, exercise serves several purposes. It keeps the mother strong enough to give birth. It helps the baby to develop a strong heart and body as well. It also keeps the mother and the baby from gaining too much weight. A large baby can make the birth longer and more difficult. Therefore, women were encouraged not to lay around, especially after eating while the meal digests. Walking and berry picking are examples of activities that were recommended for pregnant women.

Age was also taken into consideration in traditional midwifery practices. Old women were discouraged from having babies because their pelvic bones became too weak to support pregnancy and sometimes this resulted in serious injury. In cases of arranged marriages when the girl was very young, the couple were not allowed to have intercourse until she was old enough to safely bear children.

Midwives also taught mothers-to-be about the cultural values and principles associated with pregnancy. Many of these had to do with patterns intended to encourage a smooth and swift delivery. Mothers were told never to linger in doorways, to always exit the door without stopping. They were also taught not to stare out of windows. When their minds were set to do something, they were told to do it without stopping to ponder or doubt the decision.

Silence is highly valued in Yup'ik culture and for the birth, women were expected to be quiet. "The rule, during the delivery process, is not to make a

sound, because you don't want to disrupt the spirit of the environment that the child is going to go into" (John 2011). Dr. John said this was one of the most shocking experiences for her mother the first time she gave birth in a hospital; it made her very uncomfortable and sad to hear the other women screaming.

After the child was born, men were strictly discouraged from allowing the infant's urine to touch their hands. This admonishment was even stronger in the case of female infants. The smells of the infant would ruin the men's luck as a hunter. In cases when the mother did not survive, the child was usually given to her closest relatives or to an older sibling instead of to the father, especially if there was another nursing mother who was available and appropriate for raising the child.

Pregnant women were encouraged to talk to other mothers. Singing to the fetus and telling it stories was recommended. Despite all these preparations, mothers were also taught not to talk about the baby becoming human. The Yup'ik believed that the spirit was listening and so reverse psychology was important. Women were not supposed to assume the baby would live, so they were told not to think of names or make baby clothes until the child had arrived safely. It is important to note that Alaska Native knowledge systems (as with most cultures' knowledge systems) do not consider spirituality as separate from physical existence (Kawagley 2010). On the contrary, integration of the spiritual aspects of physical experience is a cornerstone of Alaska Native's and most other indigenous peoples' epistemologies.

The practices Theresa John described all took place before she was born. By the 1950s, hospitals had been established in Bethel and around the state of Alaska. Women were encouraged to deliver their babies there instead of in the traditional ways, and she reports that most of them did. They left their homes in the village a month before the baby was due and stayed in prematernal homes, away from their families.

Dr. John mentioned one village near Bethel where the traditions are still very strong and in practice, but she did not state that babies are born there. She also said that there are still women who are knowledgeable in the traditional ways of birth, who will talk to mothers and give them unofficial guidance during their pregnancies. But she said it is not the same role as the traditional midwife. It also happens occasionally that a woman delivers very suddenly, well before her due date, and so the baby is born in the village. But in general, mothers are all encouraged to deliver in hospitals in the main hubs around the state and the vast majority of them do so.

During the twentieth century, Alaska Native traditions were explicitly and systematically suppressed by the American government through policies such as boarding schools where children were separated from their families and prevented from speaking their own languages or eating their traditional foods. These assimilation tactics coupled with the devastation wrought by disease have resulted in significant decrease in the practice of Alaska Native traditions, although there are currently efforts to document and reinvigorate indigenous cultures. Despite having such a rich, and relatively recently intact, indigenous culture compared to other parts of the world, research indicates that Alaska Native midwifery traditions are not widely used, nor do Alaska Native traditions inform the midwifery practice that does take place around the state. Even though Shirley Davis, the very first midwife licensed in the state of Alaska, was an Alaska Native, at the August 2011 Midwives Association of Alaska (MAA) annual conference, no Alaska Native practices were discussed. The practices that were discussed descended from European and American cultures. If there is an Alaska Native OOH birth culture today, it exists outside of formal licensure. Moreover, both Talia and Claire stated in their interviews that AFH&BC receives very few Alaska Native clients. Whereas Alaska Natives have adapted to giving birth in the hospital, going to a freestanding birth center would mean entering yet another foreign culture to give birth.

In the American south, where African American granny midwives have a long and rich history, African American women tend to choose hospital care because of the racial, cultural, and economic stigmas associated with midwifery, and this type of stigma may apply to some extent for Alaska Natives as well (Craven 2006, 315). In Alaska, as in the south, it tends to be white families that seek out midwifery care. CDC statistics based on birth certificate records indicate that the OOH birth rate for American Indians and Alaska Natives is lower than for other ethnicities and is not increasing (MacDorman, Mathews, and Declercq 2012, 2).

Whether Alaska Natives are practicing or not, it is clear that the midwifery that is openly practiced in the state of Alaska draws mainly on European traditions. While Alaska Native birth knowledge is not necessarily part of the practice at AFH&BC, it is useful to document knowledge of indigenous birthing practices in a thesis about OOH birth practices in Alaska because they do still influence the culture, even if only subtly.

## **Chapter 3: The Alaska Family Health & Birth Center Setting**

### **3.1 The Midwifery Model of Care**

This section will define the midwifery model of care and explain the difference between a midwife and an obstetrician, as well as the different types of midwives currently practicing in the US. It will also define out-of-hospital (OOH) birth, and explain the concept of a freestanding birth center.

The Midwives Alliance of North America (MANA) is the organization that created the Certified Professional Midwife credential, which all of the midwives hold at AFH&BC. The MANA website defines the midwifery model of care:

The Midwives Model of Care is based on the fact that pregnancy and birth are normal life events. The Midwives Model of Care includes:

1. Monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle,
2. Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support,
3. Minimizing technological interventions and,
4. Identifying and referring women who require obstetrical attention (Midwives Alliance of North America 2012).

### 3.2 Different Types of Birth Attendants

Obstetricians (OB) are surgeons who specialize in childbirth. Usually obstetricians are also gynecologists, who are specialists in all female reproductive health. These doctors complete full medical school and residency.

Midwives do not attend medical school. There are several different types of midwives, and the scope of their practice varies from state to state. In general, there are three main categories of midwives, distinguished by the type of training they receive.

Certified Nurse-Midwives (CNM) have attended nursing school and completed an additional requirement in labor and delivery. In some hospitals a CNM can be the chief attendant at a birth. In other places they must work under the oversight of an OB. The American College of Nurse-Midwives is the national body that gives accreditation to Nurse Midwifery programs. CNMs usually work in hospitals, although some also choose to attend out-of-hospital births as well. As of 2010, 96 percent of CNM-attended births took place in hospitals (Martin et al. 2012, 9). Of the births that take place outside the hospital setting, 28.8 percent were attended by CNMs (Martin et al. 2012, 9).

Certified Professional Midwives (CPM), also known as Direct-entry Midwives (DEM), do not attend nursing school. Their training focuses entirely on birth, and includes both academic coursework and clinical experience. This clinical experience often takes place in the form of an apprenticeship with a practicing midwife. The CPM credential is overseen by the North American Registry of Midwives (NARM) which was created in 1987.

Finally, there are “plain midwives” or “lay midwives.” These are women with no formal certification, although many of them have extensive experience and knowledge. There are many reasons why women choose to be plain midwives including religious conviction, rejection of the perceived commodification and co-optation of a natural physiological process, tradition, or lack of access to formal midwifery training.

Doulas are also worthy of mention here. While the profession is relatively new, it is rapidly growing. Doulas are not medical professionals. A doula serves as emotional and logistical support for parents during and sometimes also after birth. Doula certification is available through independent agencies, but it is not required for practice by the state of Alaska.

Out-of-hospital (OOH) birth is simply birth that does not take place in a hospital. Usually the term refers to births that are planned to take place outside the hospital setting. Accidental OOH birth is usually referred to as “precipitous labor.” Statistics have often mixed the two together but birth certificates in many states now indicate whether an OOH birth was planned or accidental. The term “out-of-hospital” is new, but encompasses the variety of circumstances within the growing trend of giving birth outside the hospital. This term was used in a recent CDC study on OOH birth (MacDorman, Menacker, and Declercq 2010). In the past, literature has used the term “home birth” to represent all OOH birth, but that term does not capture the growing number of births taking place in freestanding birth centers, friends’ homes, and even hotel rooms, as parents strive to find the best balance of care for their families.

A freestanding birth center is a place that is not connected to a hospital where women come to give birth. This can be a point of confusion because some hospitals also contain “birth centers” that are geared toward natural birth and are staffed by hospital personnel.<sup>12</sup> The term “freestanding birth center” is being used increasingly in order to distinguish the difference.

### 3.3 The Legal Context

The laws regarding OOH birth differ from state to state. In Alaska, midwifery is legal and midwives are licensed by the state occupational board, which has its own licensure requirements. The professional titles used by the

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<sup>12</sup> For more on this topic, see Rothman, Barbara Katz. *Laboring On: Birth in Transition in the United States*. Taylor & Francis Ltd., New York, 2006.



state of Alaska are DEM and CNM. The midwives at AFH&BC are certified by the state as Direct-entry Midwives (DEM). They are also certified by NARM as Certified Professional Midwives (CPM). The Alaska DEM license has more requirements than the national CPM credential, mainly clinical experience providing continuous care from prenatal to postpartum as the primary caregiver, with oversight by a preceptor.

Midwives are legally allowed to attend low-risk pregnancies, as defined by a list of criteria. Midwives are legally not allowed to attend births of breech babies, twins, or vaginal births after previous cesarean births, known as VBAC. OOH birth is not allowed before 37 weeks or after 42 weeks gestation. Midwives cannot administer epidural anesthesia or perform cesarean births.

Midwives in Alaska may be reimbursed by Medicaid and private insurance, which Claire says plays a significant role in making midwifery a viable profession in a given area and making midwifery-style care available to families of that area.

Midwifery became legal in Alaska in the mid-1980s. Prior to that it was “alegal.” As Claire explained in her interview: “Any attorney will tell you, alegal is illegal if it really comes down to it” (Taylor 2011). Claire vividly recalled a day in 1984 when she was at home and heard an announcement on the radio that midwifery was going to be made illegal. The midwives of the state rallied together and proposed legislation to make the practice legal, and it passed unanimously after only one session. The state did not want to create a regulatory board for this new profession, so it was decided that the Midwives Association of Alaska would regulate itself, “which was sort of a fiasco,” Claire recalled with humor. “It’s like herding cats” (Taylor 2011). In 1993 the midwives went back to the legislature and finally it created a board and licenses.

Because there was not a regulatory board in the 1980s and early 1990s, several basic rules were written into the law itself to provide boundaries for appropriate care. Consequently, the rules are very difficult to update. Having the

rules written into the law itself means that in order to change the rules and keep up with current information, the entire law has to be changed. This requires educating legislators who have little or no background on medical practice or birth, rather than relying on professionals familiar with the field. It opens up the profession to potentially negative changes from opponents of midwifery care.

Claire acknowledged that the laws are not perfect. She would like to see the educational requirements updated. She also believes that the rules are unnecessarily limiting in some ways. Nevertheless, she is adamantly supportive of them because they make it possible to help more people. Without legal status midwives could only work with what she called “elite home birthers.” She said, “My vision is bigger than that” (Taylor 2011).

It is useful to understand the legal issues that direct-entry midwifery faces in the current national and world context. There are still nine states (and one district) in the U.S. where the practice of midwifery by anyone other than a Certified Nurse-midwife is illegal: Alabama, Illinois, Indiana, Iowa, Kentucky, Maryland, North Carolina, Pennsylvania, and South Dakota, as well as Washington D.C. Additionally, there are twelve states in which it is “Legal by judicial interpretation or statutory inference” or “not legally regulated, but not prohibited.” These are Kansas, Massachusetts, Maine, Michigan, Mississippi, Missouri, Nevada, Nebraska, North Dakota, Oklahoma, Ohio, and West Virginia. There are also two states, Hawaii and Georgia, where direct-entry midwifery is “legal by statute but licensure [is] unavailable” (Midwives Alliance of North America 2011).

Olivia commented that the rules in Alaska are strict compared to other states where, for example, midwives are allowed to attend VBAC, twins, and breech births. Issues of gestational length are also left up to the midwife’s own discretion and experience in some places.

VBAC is a particularly contentious issue. Not only are midwives prohibited from attending VBACs in many states, but many obstetricians and hospitals will not deliver VBACs as a matter of policy.<sup>13</sup>

There is a growing national trend of planned unassisted childbirth known most commonly as “UC” (Freeze 2008). This author is aware of at least one planned UC in Fairbanks due to the prohibition against midwives attending VBACs,<sup>14</sup> and other UCs in rural Alaska as a matter of preference.

### 3.4 Participant Demographics

Participants ranged in age from twenty-two to fifty-four. The highest achieved education levels for the mothers included one high school diploma with some college, one culinary arts degree, one International Board Certified lactation consultant and La Leche League leader, and two masters degrees, one in environmental chemistry and one in seminary. Religiously, both midwives and mothers identified themselves as either Christian or spiritual but not affiliated. All mothers and midwives are white except for one who is Chinese-American. The mothers' marital status included three married, two single, and one divorced and remarried. Four of them delivered their babies at the birth center and two at home with the midwives in attendance. Only one mother had grown up in Alaska; the others had moved to the state as adults. Of the midwives, two grew up in Fairbanks and two moved here as adults, although all of them had been in Alaska for two to three decades at the time of their interviews. The mothers included three first-time mothers, one mother with five children, one mother with four children, and one mother about to birth her second child. These mothers' previous births had taken place at one Canadian hospital, one American hospital, one American military hospital, and one home in Minnesota (attended by a midwife).

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<sup>13</sup> See Section 8.2 regarding liability issues faced by doctors.

<sup>14</sup> For more discussion on the issue of VBAC, see Freeze 2008.

### 3.5 Study Participants and What Brought Them to AFH&BC

This section will introduce the participants, including age, hometown, education, work, and what drew them to midwifery practice or care. There are four midwives at AFH&BC: Claire Taylor, Deborah Donnan, Genevieve Reid, and Talia Schaefer. All of them did part or all of their clinical training at AFH&BC, as apprentices.

#### Claire Taylor

Claire is fifty-four years old. She is the Executive Director of AFH&BC. She says she was drawn into midwifery by her own births and wanted to give other women the same access to options. Claire gave birth to her first child at home with a midwife at the age of nineteen. After the birth of her second child, she suffered a significant postpartum hemorrhage. She and her baby were both fine but the experience illustrated to her the importance of having skilled birth attendants. When she moved to Alaska in her late twenties, she did not think there were midwives in the state. In actuality, home birth was relatively common, and Claire soon met Vicki Penwell, the founder of AFH&BC. Claire started her apprenticeship with Vicki in 1984 and says she was struck by Vicki's drive for excellence in her practice. Claire also traveled to New Mexico and trained with Elizabeth Gilmore, who became a prominent figure in the American OOH birth movement during her life time. The curriculum that she developed for Claire later became the basis for the curriculum that is still in use for licensure today. During her interview, Claire recalled being fascinated as she was growing up by animals giving birth. In retrospect, she said, it is no surprise that she became a midwife.

#### Deborah Donnan

Deb is also fifty-four years old. She is the Administrative Director of AFH&BC. Her father was in the military and that brought her family to Fairbanks

when she was fifteen. She later married a man born and raised in Fairbanks, so Alaska is home to her. Deb is the wife of a non-denominational Christian pastor. She did her training at AFH&BC and has been a midwife for nineteen years. She has participated in approximately seven hundred births. She attends fewer births now, spending more time teaching the childbirth preparation class and compiling the AFH&BC statistics. She is also on the Alaska State Board for Certified Direct-entry Midwives. She became interested in midwifery after having her second child at the birth center. She was fascinated with birth and wanted to provide the same experience for other women. “It’s just such a miracle when birth occurs, there’s just nothing like it. It’s such an amazing moment in time when you see a new life come into the world. It’s a very spiritual moment” (Donnan 2011b).

#### Genevieve Reid

Genevieve is forty-one years old. She grew up in northern Nevada but has been in Alaska, where her sister also lives, since 1992. Genevieve is tall, with an enigmatic personality. When asked why she likes working at AGH&BC, she said:

I like helping moms and babies. I like being a guardian of birth. I like to witness the awesome power of a woman and the . . . exquisite part of bonding and attaching to a baby, and a baby to a mom, at birth. I like giving families a choice in where they have their babies, and I don’t think the hospital is a place where people should have babies if they’re healthy. . . . Because I don’t think there is that awareness of what is actually happening. It’s a medical procedure, that usually needs, as far as they’re concerned, needs to be managed and controlled” (Reid 2011).

Genevieve’s training included academic distance courses through Via Vita Health. She apprenticed under Suzanne Rich and then Claire, starting in 1993. She has participated in approximately eight to nine hundred births.

### Talia Schaefer

Talia is twenty-nine years old. She was born and raised in Fairbanks. She was first exposed to midwifery when she had the opportunity to witness her friend's birth with AFH&BC. Talia has been a licensed midwife for about one and a half years and has attended approximately two hundred births. She has always been interested in women's issues and women's health, so midwifery was a good fit for her. She said that Claire was a demanding preceptor, but that the rigors of the training match the demands of the job. She did the majority of her clinical and academic training through a birth center called Maternidad La Luz in Texas, but returned to Alaska to complete her clinical apprenticeship and begin practicing. Talia is known for her gentle voice and her humility. "I'm just a baby midwife," she often says. "It's an honor to work with our moms and families here" (Schaefer 2011).

There are six mother-participants in this study.

### Jane Schoenfeld

Jane is thirty-six years old. She was born out of state but moved to Alaska when she was two and considers Fairbanks home. She is a mother of four and the co-owner of an organic baby products store in Fairbanks. She had given birth with the AFH&BC midwives twice before her most recent pregnancy and described herself as a veritable poster child for home birth. Jane is married and holds a master's degree from a seminary in Vancouver, BC.

### Megan Boswell

Megan is thirty-four years old. She is a first-time mom who grew up in Texas but has lived in Alaska for over a decade and considers it home. Megan chose AFH&BC because she wanted an OOH birth with little intervention. She moved to Fairbanks in the middle of her pregnancy and knew at least two other people who were using AFH&BC for their prenatal care and birth, as well as

another acquaintance who had had multiple unassisted births. Megan is not married and is taking classes towards a nursing degree.

#### Sienna Carter

Sienna is twenty-two years old. She is from Kansas City and very much identifies with that city as her home. Her husband is from Fairbanks and his parents and extended family still live here. They are in Alaska for his job but intend to move back to Kansas City eventually. Sienna was in favor of having a home birth and several of her husband's family had used the birth center before. "When we got here, I called every place—clinics, hospitals—to decide what I wanted to do, and everyone was rude, except for the birthing center. I don't like care that doesn't really care. I wasn't set on [the birth center]. I'd always wanted a water birth and other places here offer water birth. I wasn't really set on midwives. I didn't go in thinking this is exactly what I'm going to do. It just fell into place and I really love the decisions I made" (Carter 2011).

#### Lena Fischer

Lena is twenty-nine years old. She is from Indiana and came to Alaska to attend graduate school. She earned her master's degree in environmental chemistry at the University of Alaska Fairbanks. She has a five-year-old son and is twenty-two weeks pregnant with her second child. When asked why she chose the birth center for her upcoming birth, Lena said that it seems more natural. "I have a five-year-old already and I went there for him. My friend had done her birth through a midwife and I just prefer that method. I don't really like doctors. [How come?] I think there's too much going on for the simple act of giving birth" (Fischer 2011). When asked how her background in environmental chemistry influenced her decision, she said it did not play much of a role. "I don't like to take a lot of medicines," she volunteered (ibid.).

### Cara Thomas

Cara is thirty-two years old. She is a mother of one with a degree in culinary arts. She owns a small business making herbal teas and body care products. She also works at a locally owned grocery that specializes in Alaska-grown meat and other products. Cara moved around as she was growing up. She spent the most time in New York but does not identify with the New York as home. Fairbanks is the place she has lived the longest, where she has developed the most community, and feels most at home.

Cara did extensive research and although she was very afraid of the pain, she felt that the most natural option was the best for her and her child's health. She was specifically very drawn to the water birth option. "I was becoming more aware of how important it is to live more naturally. I was becoming more aware of how it affects my body, just being as I was pregnant and wanting to do the best I could for my baby. I did research and saw what was available and saw that there was a birth center. I have this immense love for water. . . . So it kind of, worked well together. I think just the matter of educating myself on . . . why giving birth naturally is better for the mother and baby" is why she chose AFH&BC (Thomas 2011).

### Olivia Scott

Olivia is thirty-three years old. She is from Minnesota. Her husband, Troy, is in the army and that is what brought their family to Alaska. Most people call Olivia "Liv". Liv has been a La Leche League leader for eight years and recently became an International Board Certified Lactation Consultant. She is also training to teach birth art.

Olivia had had three previous births in hospitals with obstetricians. When she moved to Alaska, she noticed that, compared to other places that she had lived, "birth seemed to be going really well here. I thought, this is really cool! They don't even need me here! [as a lactation consultant]. If we have another child, I want to do it in Alaska" (February 2012). Liv and her husband were not



necessarily planning on having more children. Then when she learned she was pregnant again, her husband deployed a week later. In order to have more help from family, she and her three older children went back to Minnesota and she had a home birth there. Back in Alaska after her husband returned, she found herself pregnant again and knew immediately that she wanted to do a home birth with AFH&BC. Liv had a lot to say about deciding where and how to birth:

This isn't just about a choice I make for that one day in my life. This is about the atmosphere that we live our life in. . . . It's not just should I wear a red shirt or a blue shirt today? It's also about the cascade of interventions and how it will impact how you going forward too, how you are able to breastfeed, how you bond, how you recover emotionally and psychologically and hence how you are able to parent. There is a ripple effect outward.

Liv knows this from her own experience as well as from eight years of experience as a La Leche League leader, helping mothers during the postpartum period with breastfeeding issues. As mentioned before, Liv noticed immediately when she moved to Alaska that the birth culture was different, and seemed very positive. When asked how it was different, she said that OOH birth was much more common, and that women were much more likely to seek OOH birth for their first child than in other places she had lived. "People in Alaska just tend to march to the beat of their own drummer more," she said. As an example, she began talking about the transfer station. Now there's a place to do an anthropological study! "You see these people, and they're driving nice cars, new cars, and they've got these contraptions that they've made for reaching into the dumpsters!" she recounted with a mix of delight and wonder. "Do you know Kelley? She has an entire route! She and the kids go around to all the different transfer stations and they find the coolest stuff!"

Liv also cited the voluntary choice that many Fairbanksans make to live without running water. Liv knew of many people who intentionally chose to live in

these “dry” cabins and used cloth diapers for their babies. Whereas this would indicate extreme poverty in most parts of the country, again, Alaskans seemed to view it as a practical response to the problems posed by the extreme climate.

### 3.6 AFH&BC Statistics, Legal Status, and Funding

	2010	2011
Total Births	121	104
Home Births	19 percent	23 percent
Transport to Hospital for Support	10 percent	12 percent
Cesarean Births	3 percent	<1 percent

(AFH&BC 2011, 1; AF&BC 2012, 1)

According to the State of Alaska Bureau of Vital Statistics, Fairbanks Memorial Hospital’s (FMH) 2009 cesarean rate was 27 percent. In 2009, AFH&BC delivered 8.5 percent of the total births attended between FMH and AFH&BC. The year 2009 is the most recent year for which this data is available (State of Alaska Bureau of Vital Statistics. “Method of Delivery by Facility for 2009”).

AFH&BC is accredited by the Commission for the Accreditation of Birth Centers. It is a non-profit organization and receives some funding through donations from individuals. It does not receive public money for operation except as fees for services rendered.

### 3.7 Out-of-Hospital and AFH&BC Demographics

It is important to note that while AFH&BC has very good statistical outcomes, the current trend of midwifery is taking place within a population that is generally very healthy. Furthermore, in accordance with state law, all high-risk

cases are referred to obstetricians. Therefore, the AFH&BC cesarean rate is artificially low.

During her interview Claire was asked about this. She pointed out that in the American past, and in many parts of the world today, midwives have worked with marginalized people. These include the poorest, most overworked, and least nourished populations. At Vicki Penwell's current practice in the Philippines, prenatal care is entirely different than that received by AFH&BC clients because mothers are routinely facing issues like tuberculosis and malnutrition. Nevertheless, Vicki still has overwhelmingly positive outcomes, said Claire. She attributed success to the midwifery model of care.

AFH&BC client demographics are fascinating. While exact numbers are not available, anecdotally, they are as follows. Families of all ages use the birth center. Talia estimated the most common ethnic minority to be Eastern Europeans. Claire stated very few Alaska Natives use AFH&BC. Politically, clients range the entire spectrum, from far right to far left, with most people being somewhere in the middle. Some people come motivated by a religious conviction. Elizabeth, one of the midwives who trained at AFH&BC and occasionally helps out, works most of the time in a religious community in Delta. Another segment of the AFH&BC clientele could be labeled as the slice of Fairbanks culture that lives in dry cabins in Goldstream Valley or along Chena Hot Springs Road. Talia admits that when she began training at AFH&BC she thought this description would characterize most of the clientele. She was surprised to find that they are not the majority. She described most of their clients as "pretty mainstream" (Schaefer 2011). Participant observation confirmed this very generalized assessment. Despite the many stereotypes surrounding midwifery care, the birth center seems to draw a wide spectrum of the community, including groups that otherwise might not share many other views or interests. A dad with camouflage hunting pants is not an unusual sight at the birth center. He could be an NRA-endorsing Republican, a dog-mushing

environmentalist, or an NRA-endorsing environmentalist. He could make a six-figure salary on the North Slope and live in a large, modern home, or do construction in the summer, not work half the year, and live in a small cabin with no running water. A person would not know the difference unless she asked. This is a reflection of Alaskan culture, but it also characterizes midwifery nationwide.

As Christa Craven writes:

Advocacy for midwifery is a profoundly diverse effort, particularly in terms of religious and political affiliation. Fundamentalist Christians often stand alongside pagans and Buddhists at rallies, and Democrats, Republicans, Greens, and Libertarians put aside political differences to hold signs that read 'Affordable Healthcare Begins with Midwifery' (Craven 2006, 331).

The National Birth Center Study II included demographic data of its 15,574 participants. Three-quarters of the women were white, 11 percent were Hispanic/Latina, 6 percent were African American, 2 percent were Asian, 1 percent were Native American, and 3 percent were of other racial categories. Most of the women were between the ages of eighteen and thirty-four (85 percent). Fourteen percent were thirty-five and older and 1 percent was less than eighteen years old. Most of the women were married (80 percent), and 72 percent had at least some college education. About half the women were pregnant with their first baby, while the other half were experienced moms (Stapleton, Osborne, and Illuzi 2013).

## Chapter 4: Prenatal Care

### 4.1 A Prenatal Care Appointment with Sienna

Sienna sits in the lobby, waiting for her thirty-eight week prenatal appointment. Another woman and her small son walk out from the clinic and go to the front desk to confer with the receptionist. The little boy goes to play with some of the toys in the lobby. Sienna has already gone to the bathroom to test her urine for the day and now she sits, flipping through one of the pregnancy books from the lending library. The walls are a warm, coral color and the furniture is wicker. A mirror reflects the light from outside. A corkboard covered with pictures of past babies and parents hangs on the wall.

Genevieve comes out the door of the clinic and smiles at Sienna, grabbing her chart and welcoming her into one of the two exam rooms. They enter the first, which is long and narrow with a sliding door. In many ways it looks like a normal doctor's office: cabinets, a counter, a sink, diagrams, and jars. A dollhouse sits on one side of the room, a wicker bench with a floral print cushion on the other side. At the far end of the room is an exam table. The walls are off-white with wood trim. The cabinets are light-colored wood with metal, fish-shaped handles.

Sienna sits on the wicker bench with her arm on the counter and Genevieve takes her blood pressure. They discuss billing for a couple minutes and then Sienna hands Genevieve a salmon-colored piece of paper. All clients are given a questionnaire around thirty-seven weeks about how the mother would like the birth to go, what are her fears and needs, etc. They use the questionnaire instead of a "birth plan." The tone of conversation is very relaxed and familiar. Nobody is rushed. Genevieve remains in the room the entire visit, about an hour. Genevieve looks over the birth plan and reassures Sienna that her fears are normal and manageable. "All of my fears are so extreme!" Sienna

laughs (Carter and Reid 2011). She says she is not afraid of the pain. She is confident that she can do it. She's just afraid of the big things, "like dying!" she emphasizes (ibid.). "Birth and death are very close," Genevieve acknowledges (ibid.). Genevieve reassures Sienna that they will take care of her.

As far as how she envisions the birth, Sienna talks about how she looks forward to having the midwives over like guests at her home birth, there to calmly celebrate a birthday party. Genevieve points out that she doesn't have to treat them like guests and says that the midwives may leave and go for walks or coffee so that she can have privacy during labor.

Without exchanging a word, both Genevieve and Sienna stand up and walk over to the exam table. They begin the familiar process of measuring the belly, assessing the fetal position, and listening to the baby's heartbeat with a hand-held doppler. Everything looks and sounds good. Sienna talks about where her daughter's bottom is and how she can feel the baby pressing down on her cervix, as if the baby is already trying to escape the tight confines. Sienna wants to go into labor before her due date and talks about it as if this outcome is certain. "I'm trying to will it into existence," she explains (ibid.). She herself was born early, so she sees an early delivery as entirely possible. Genevieve says that it is not likely, from a statistical standpoint, but hopes for Sienna's sake that she is wrong.

Sienna is as confident about the baby being a girl as she is about an early delivery, but the gender she has had confirmed multiple times by ultrasound. This will be the first girl in her whole family and Sienna had been excited to be absolutely certain of the baby's sex. The midwives routinely send women to have one ultrasound at the beginning of their pregnancies to confirm the gestational age, because an inaccurate due date can result in a hospital transfer if labor begins before what everybody thinks is thirty-seven weeks or after forty-two weeks. It is also common for mothers to have a second ultrasound at twenty

weeks to check the baby's gender. As with all prenatal tests, these two ultrasounds are optional.

Having assessed the baby's position, checked the heartbeat, and measured Sienna's belly with the measuring tape, they are done on the exam table. Vaginal exams to check cervical dilation are not performed during prenatal care unless specifically indicated or requested. Genevieve gives Sienna a hand sitting up and stepping down from the table.

Sienna and Genevieve resume their seats and discuss a few more questions before departing. Genevieve asks Sienna, "Do you care to check your weight?" (ibid.). There is a scale down the hallway, one with actual weights rather than a digital readout. The midwives rarely check a mother's weight, and do not impose limits or recommendations on weight gain, focusing instead on good nutrition. Sienna, however, has already weighed herself that morning and is quite well aware of how much she weighs and how much she has gained over the course of her pregnancy. "I weigh two hundred and three pounds! *Two-oh-three!*" she emphasizes, pointing at herself (ibid.). Genevieve reassures her that the amount she has gained is normal and healthy, and while it feels like a lot, Sienna acknowledges that Genevieve is right.

Genevieve asks how her urine was. "Good urine," Sienna says in her inimitable way (ibid.). Mothers test their own urine before the start of every prenatal appointment. The test strips are in a jar by the toilet and there are directions posted on the wall about how to cleanse, catch the sample, and dip the strip. The strip has five tests on it: glucose, leukocytes, nitrite, protein, and blood/hemoglobin. Claire stated that they see greater success with the urine strips when mothers test themselves as opposed to the midwives dipping the strips. Sienna notes that ever since she started making her appointments in the afternoons her urine has been better.

Genevieve asks if Sienna has any other questions, which she does not, and then declares that everything sounds great. "Now it's just a waiting game,"

Genevieve says in closing (*ibid.*). Sienna reinforces cheekily that she will go into labor before her due date, but she will schedule her next prenatal appointment anyway as she and Genevieve pick up their belongings and depart.

#### 4.2 The Childbirth Preparation Class with Deb

Within the OOH birth movement there are many different types of childbirth preparation formats from classes and multi-week courses to books that rely on a variety of techniques, theories, and philosophies. Deb provides a four-hour Childbirth Preparation Class for the birth center once a month. The class is optional and the cost is \$50. Mothers, fathers, and other birth partners are encouraged to come.

On a sunny Saturday in February, three couples are attending the Childbirth Preparation Class. Their ages range from twenty-four to thirty-two and they are dressed casually. The class is held in the lobby of the chiropractic office in the same building as the birth center. Deb introduces herself and shares a bit about her own background and birth history. She is wearing a black leather vest with tassels.

Deb begins the class by showing a diagram of the pregnant body and how the internal organs are reorganized to accommodate the full womb. She compares the uterus to a swimming pool and encourages the ladies to drink plenty of water.

The main topic of the class is the process of labor and how to recognize it. “You have to call the midwives if your water breaks,” she starts (Donnan 2011a). Legally, labor must start within twenty-four hours of the water breaking. It is also important to check for the presence of brown or green meconium<sup>15</sup> when the water breaks. Amniotic fluid should be clear. She notes that babies are only allowed to be born at the birth center between thirty-seven and forty-two weeks of gestation. If labor starts before or after that range, it is necessary to go to the

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<sup>15</sup> Meconium is fetal excrement in the amniotic fluid.



hospital because premature babies' lungs are not fully developed and they can not yet process food. This makes it especially important to determine an accurate due date. An ultrasound at eight weeks is the most accurate for determining fetal age.

Deb explains how to time contractions from the beginning of one to the beginning of the next. As far as what to expect going into labor, she tells her audience to, "Be flexible! It's very different for everyone and you just don't know until it happens. Maybe your water breaks, maybe you start having contractions. Maybe you lose your mucus plug or have bloody show. And sometimes the birth will still be days or more away at that point" (ibid.). Other common indicators include loose stool and a sudden burst of nesting energy. Deb explains the concept of cervical dilation as measured from zero to ten centimeters.

"Active labor is when contractions are too uncomfortable to talk through," she continues (ibid.). For some women, the first contraction drops them to the floor, while other women are in mild, early labor for hours or days. She explains the difference between labor contractions and painless Braxton Hicks contractions.<sup>16</sup> These are the uterus working out in preparation for the birth and they tend to be more common in older women. She reassures them, "If you're not sure you're in labor, then you're not" (ibid.). She tells the expectant mothers to look for contractions that are less than five minutes apart that last from forty-five to sixty seconds. Contractions that are two to three minutes long are still early labor. As a general rule contractions become stronger and closer together as labor progresses.

Here Deb touches on the topic of pain. She tells the group, "99.9 percent of women experience some pain—it's just part of the process. Relaxation helps, but doesn't take the pain away. It's not wrong if you have pain" (ibid.). Deb says

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<sup>16</sup> In 1872 Dr. John Braxton Hicks distinguished between labor and these muscle contractions that do not dilate the cervix or signal the onset of labor. These contractions tone the uterus in preparation for birth. They can start as early as the second trimester but are much more common in the third trimester. Usually braxton hicks contractions are painless, like clenching a fist.

that she has never seen a painless labor. “You can be very calm,” she concedes (ibid.). Deb recounts how her husband thought she was sleeping and nearly left the room just before their son was born. Being quiet and still was just her way of coping. “Do *whatever* you need to do,” she emphasizes, “whether you get loud or quiet. Practice relaxing before you go into labor” (ibid.). She adds that hypnosis techniques have been very successful for some people and are worth considering.

Deb recommends rest and hydration during early labor. Usually women become nauseous near the end, “so eat nutritious, high-protein food like eggs and yogurt or peanut butter and toast,” she suggests (ibid.). She tells the women to try to eat every two to three hours, reminding them that eating gives the baby energy too. She adds that an electrolyte beverage is helpful, ideally one that is naturally sweetened because sugar can increase the perception of pain. “Gatorade has a lot of sugar,” she notes (ibid.).

Early labor can last a long time, she says. It can start and stop and go on for days. Conversely, some women go straight to active labor. “Stay home as long as you can,” she emphasizes (ibid.). She tells the group that six to seven centimeters is a good time to arrive at the birth center, if the birth will be taking place there. “A lot of women come in at three to four centimeters,” she continues. “Then again, if you live out of town on long, bumpy roads, it’s okay to come in early. We won’t turn you away,” she reassures the parents (ibid.). She notes that being at home is good because being in one’s own environment is less disruptive to the brain and the rhythm of labor. “Distractions *can stop* labor,” she points out (ibid.). She recommends alternating between rest and activity during early labor. “Go for a walk, but then lay down to rest” (ibid.). She reminds the mothers to stay well hydrated and nourished, and not to take any medications. “If you do, the midwives need to know about it because it’s important to know if you develop a fever during labor” (ibid.).

Deb advised the women to bring food and drinks to the birth center. For a water birth, she recommends bringing several long t-shirts or gowns or a sports bra or whatever makes them comfortable if they prefer modesty. She recommends bringing several because laboring mothers usually climb in and out of the tub more than once. She adds that modesty need not be a concern. “We give lots of privacy during labor because the body works better that way” (ibid.).

“Once at the birth center, the midwives will get you settled into one of the birthing rooms, check the baby’s heartbeat, check your vitals, and possibly perform a vaginal exam,” she explains (ibid.). Vaginal exams are not frequent; at most they are usually done every four hours. Birth “takes a long time. It’s natural. That is okay,” she says (ibid.).

Deb tells the moms to make sure that their birth partners are not fearful and that they are supportive. She recommends talking before the birth to establish how the mother wants her birth partner to be, what she wants and needs, what is helpful and what is not helpful. Deb says, “They need to be there to support you. Usually moms are great but sometimes they are not used to the birth center setting,” she adds (ibid.). Two of the three women attending the class have mothers who had OOH births themselves. As explained in chapter six, fear and distractions can make the labor more difficult.

With regard to the discomfort of labor, Deb recommends reading Pam England and Rob Horowitz’s *Birthing From Within*. “Labor is hard work, it hurts, and you can do it,” she says (ibid.; an approximation of Suzanne Stalls quoted in England and Horowitz 1998, 120). Apparently it is not a favor to lead expectant mothers to believe that birth is not painful. “Pain does not mean that you’re doing it wrong. The body produces endorphins—natural pain relief that is a hundred times more powerful than morphine, by volume. Usually you get enough to take the edge off and let you into a drowsy space—the space within—and shut out the external,” Deb explains (Donnan 2011a).

Deb tells the group a story about Dr. Michel Odent. At one time in France there was a new drug that was making labor much faster and smoother. Doctors did not know at the time how it worked, only that it did. As they continued studying the drug, they realized that what it did was shut down the neocortex of the mother's brain. This is the part of the brain responsible for language and complex reasoning. By shutting this part of the brain down, labor speeded up dramatically and consistently. Deb notes that increased activity in the neocortex has been correlated with increased perception of pain. She says that reading Michel Odent's research reinforced what experience was already teaching the midwives at AFH&BC: methods like minimal talking and touching and dimming the lights had a positive effect on the birth process.

"Don't shoot the breeze or make small talk with a mom in labor," she warns the fathers (ibid.). She tells them to keep the environment mellow and keep sounds quiet, and not to talk or touch during contractions because that returns the mother to the neocortex. She balances this warning with a recollection about how important her husband's presence was during her own births. She needed him to be there and be quiet. She notes that it is not uncommon for women to push their husbands away during labor, but she explains that this is not an insult. It simply means that the woman is successfully getting out of her neocortex. "Distractions make it hurt more," she says (ibid.). Deb encourages this "going deep" during labor and says that the midwives will give privacy unless mothers want them in the room. Once pushing starts, then the midwives will be in the room monitoring until the end.

While in the room, the midwives use a hand-held doppler to check the baby's heartbeat. They remind the mom to drink fluids and help her to change positions if needed. They check vital signs every four hours. Additionally, she says, "By all means, ask if you need anything. That goes for dads and support people too" (ibid.). The midwives are happy to make coffee, she reassures the dads. "As for moms, they tend not to be real communicative in labor and that's

okay. We understand if you push us away. Politeness is not necessary,” she says (ibid.).

Transition is the end of active labor and the beginning of the pushing phase. It is often the most intense part of labor, Deb explains. This is usually when women will say they can not do it or ask for medication. Some women never have a distinct transition phase and go straight to pushing.

During pushing, contractions tend to be short, intense, and close together. Deb reminds the women that there are many breaks between contractions. They occur in wave-shaped patterns. Many women find the pushing phase to be more satisfying because instead of passively coping they can put their effort into pushing. Some people find pushing to be less painful, and sometimes the pushing stage is very fast. Usually it lasts from one to three hours however. This is when the baby is navigating the birth canal and pelvic bones, positioning for the actual birth. Pushing can be exhausting. “You have to push pretty hard,” Deb says (ibid.). She uses a model pelvis and a baby doll to demonstrate the process and reviews the anatomy of dilation. “Effacement” is the term for the shortening of the cervix. During the pushing phase the midwife will check the dilation of the mother’s cervix by inserting her fingers into the vagina. Deb says that once the cervix is dilated to five centimeters, “you can feel the baby’s head to check position and to see if the water is intact” (ibid.). She reminds the mothers that the midwives will never break the water without permission.

Deb turns to the issue of transport. The most common reason for transporting to the hospital is failure to progress, she tells the parents. She says that it is most common in first-time mothers and that usually Pitocin (a drug to stimulate contractions) and an epidural for pain are all that are needed. She does not recommend starting with Pitocin and an epidural, “but they can sure save lives when needed,” she says (ibid.). She tells the group that the national cesarean rate is over 30 percent and reassures parents that in 2010, AFH&BC attended 121 births and only four of them ended in cesareans. The transfer rate

was 10 percent, so of the several people who had to go to the hospital, most did not need to have cesareans. "If a transfer becomes necessary the midwives will go with you as a doula. The OBs are all good, some more friendly than others," she tells them (*ibid.*). She recommends one of the local obstetricians as a backup doctor, and says that another is also good but the practice is busier and harder to access.

The class takes a break. There is warm artichoke dip with crackers, salami, and miniature Valentine's Day cupcakes. Somebody asks Deb a question and she responds that the birth center serves many clients who were planning a hospital birth but changed their mind after the hospital tour.

After the break, Deb reassures everyone that the first baby usually requires the longest labor. She reminds everyone to rest during early labor because it is common to miss a night of sleep before the baby is born.

Deb explains that during the pushing phase it is common for the baby to move in a back and forth motion, down one millimeter per contraction, and then back up. The mother can reach into the birth canal and check herself to monitor the baby's progress, if she feels so inclined. The dad is welcome to catch the baby. Normally the head will come out and then the baby will turn itself and the shoulders will be born vertically. She says that about 60 percent of births at AFH&BC take place in the water. "If you have a water birth, just pull the baby up to your chest. Keep the baby's body in the water with the head up," she instructs (*ibid.*). She explains that air hitting the baby's face is what stimulates breathing so the baby will not breathe until he or she emerges from the water.

Deb stresses the value of skin-to-skin contact after the birth. This helps the baby to regulate its temperature, heartbeat, and breathing, she says. The mother's temperature is usually two degrees higher than normal after birth, so her skin is nice and warm.

She tells the parents that babies are frequently purple or blue when born, but very alert and awake. They also receive a rush of adrenaline from the birth.

They should “pink up” within twenty seconds or so. She reassures the parents that oxygen is available in the rooms to help the baby, if needed. She says this happens in 5 to 6 percent of births and usually within ten to fifteen seconds the baby starts breathing on his or her own. Deb shows everyone the oxygen bag so they know what it looks like. She discusses the amniotic fluid that empties from the lungs after the baby emerges from the liquid environment of the womb into the gaseous external environment. She also covers the need for hospital transfer if there is heavy meconium because it is bad for the lungs. She says in the case of heavy meconium, the midwives will also use suction to help clear the baby’s airway.

“After the birth, mothers need rest,” she states unequivocally (ibid.). Deb explains that the placenta leaves a spot like an open wound in the uterus, and everybody squirms as she gestures with a placenta puppet. “Postpartum recovery is a full six to eight weeks,” she emphasizes (ibid.). “If you are doing too much, bleeding will pick up again even if it had started to slow down,” she warns, adding that increased blood flow is associated with higher rates of infection and depression (ibid.). “Do not cook dinner. People want to help and participate after you’ve had a baby so let them come over and do your laundry or dishes or bring a meal,” she recommends (ibid.). She adds that it is good to take a break and let dad hold the baby sometimes. The baby has been hearing his or her father’s voice from inside the womb so he or she is already familiar with him.

Deb explains that if a hospital transfer becomes necessary, parents and babies will then be subject to standard hospital procedures. Nurses will administer a vitamin K injection for a rare hemorrhagic disease that keeps the blood from clotting during the first week. They will also put antibacterial ointment in the eyes to prevent blindness in case the mother has a sexually transmitted disease. A Hepatitis B vaccination is also standard. All of these procedures can be delayed or rejected on the consent form that is signed upon check-in. The midwives do not administer any of the above procedures at birth.

As for breastfeeding, Deb recommends a class in town with the Public Health Nurse, who is somewhat of a local guru. Deb says that every baby's personality is a little different and advises watching for signs after birth that the baby is hungry. She talks about speaking quietly to the baby and moving slowly. "Watch for his or her startle reflex," she says (Donnan 2011a).

"Babies can understand language long before they can speak it, and they can also understand intention through hormones and tone of voice. Babies are very sensitive, so talk to them," she recommends (ibid.). She tells the parents to explain what is going on to the baby, and to tell the baby his or her birth story repeatedly, be it good or bad. "We remember," she says (ibid.). She tells a story about a girl born at the birth center with a loose nuchal cord (umbilical cord around her neck). Three or four years later the little girl re-enacted her birth and having the cord unwound, much to her mother's surprise. "Babies want to tell their story," Deb says. "We help them by telling them and by talking about it" (ibid.).

Deb asks if there are any questions or topics she hasn't covered. Nobody has any questions. She emphasizes resting after the birth again. There is a little more discussion about transfer and hospital procedures. She reassures parents that transfer does not usually mean calling an ambulance. She explains that they take the time to warm up the cars and everyone drives over to the hospital together. She also points out that, "If we go for intervention then we have to accept some intervention. Sometimes you just get to a point and you need a tiny push" (ibid.).

Working toward her conclusion, Deb states that, "the goal, is for you to feel more comfortable with the process and empowered so you can do it. The key is relaxation so you can get in the space where you can shut down the neocortex. Tensing up makes the pain worse. Try to get to a point where you're not distracted. Let people know if they're being distracting. Turn off the cell phone" (ibid.). She discusses what relaxing during labor means and notes that



visualization can also be a good technique. “Visualize the cervix opening,” she advises (ibid.).

Deb reminds parents that babies normally lose weight after birth but gain it back quickly. The midwives will monitor this at the one-week, two-week, and six-week check-ups. The first three days after birth are very emotional and very teary but beyond two weeks it is important to take note of severe depression. She says that as many as 85 percent of mothers experience mild depression.

Following a couple of questions about breastfeeding and sleep, the class is concluded. While most childbirth preparation classes focus on methods for pain management and prenatal exercises, this class is focuses more on the physiological process of birth. The main thrust of the class is recognizing and assessing labor and establishing a strong labor pattern before going to the birth center, if that is the plan.

#### 4.3 Additional Notes on Prenatal Care

Women usually begin prenatal care during the first trimester or at the beginning of the second. The AFH&BC clinic is open Tuesday to Thursday for prenatal care and the midwives take turns doing prenatal appointments so that each family meets each midwife before the birth. This model serves multiple purposes. It allows the midwives to help more women than they would be able to as independent midwives. It allows the midwives to focus on patient care rather than book keeping and billing. It also allows them to have a more regular schedule, and this helps to prevent fatigue and burnout.

The midwives advise all parents to contract with a backup doctor should the need for transport arise. There are two other practitioners in town the midwives recommend, although it is up to the parents to choose whomever they like, or whether to use one at all. One of the practitioners they recommend is a male midwife who did his original training through the military. He works in the office of the female obstetrician who performed Jane’s cesarean.

With regard to fathers, they are happily welcomed in the process. Fathers commonly attend prenatal appointments (usually not all of them). Caregivers answer their questions and invite the fathers to the childbirth preparation course, but there is no specific preparation targeted at fathers.

#### 4.4 Conclusions about Preparation for Birth

Preparation for birth at AFH&BC consists mostly of prenatal care and the Birth Preparation Class. During prenatal care the midwives monitor the health of the mother and the baby. Significant emphasis is placed on building a trusting relationship between the midwives and the parents before the birth. The relationship between the midwives and the parents can be characterized as egalitarian. Mothers are not passive recipients of care. Decision-making is shared and the mother is considered a legitimate source of information about her pregnancy. The Childbirth Preparation Class The childbirth preparation class is one 4-hour session during which one of the midwives gives a talk specific to the logistics of the birth. Fathers and/or other birth partners are encouraged to attend and everyone has the opportunity to ask questions. Whereas most childbirth classes have traditionally focused on pain management, either through breathing, hypnosis, coaching, or epidural anesthesia, this class focuses on the physiological process of birth. The class is centered around recognizing the onset of labor and establishing a strong pattern of labor at home.

During the interviews, it was not uncommon for mothers and midwives to respond with a blank stare after being asked how the midwives prepare people for birth. Confused, they would pause and say, "Well, there's the birth preparation class." It was clear that neither the midwives nor the parents perceived the midwives as "preparing" the parents for birth. The response that eventually came from every mother in the study was "listening." Listening is the most effective preparation for birth, they reported. The practice of listening allows families to

address their concerns and establish a trusting relationship with the midwives. This helps the mother to approach the birth feeling safe and positive.

These data revealed that, to a certain extent, the question, “How do the AFH&BC midwives prepare clients for birth?” assumes a hierarchy between the midwife and the parents. It frames the issue in terms of midwives teaching parents what they need to know about birth. While the midwives do have significant experience with birth, as Claire explained in her interview, “Everyone is a social equal” and that is a cornerstone of the practice at AFH&BC (Taylor 2011). Egalitarianism is very highly valued in the culture at AFH&BC and this is reflected in the practice.

This approach to prenatal care also begins to reveal the relationship between midwives and the notion of control in pregnancy and birth. The midwives at AGH&BC acknowledge that they do not control these processes. Verbs such as listen, monitor, and observe show that midwives interact with pregnancy rather than controlling the process. By recognizing patterns, they can suggest behaviors to facilitate good outcomes and respond appropriately when a pregnancy begins to progress in unfavorable directions. This attitude toward control will be seen again in the chapter about intrapartum care. This attitude corresponds to the rite of passage framework that views pregnancy and birth as a naturally occurring passage, to which a culture must respond.

## **Chapter 5: Birth Stories**

### **5.1 Participant Birth Stories**

This chapter is composed of birth stories from four of the mother participants. Birth stories are an important form in the field of OOH birth. They represent women speaking directly to women, telling their own stories in their own words. In this context, birth stories provide a means of introducing the practices at AFH&BC that captures the physical, psychological, and social elements of the practice, as well as the participants' perceptions about this model of care.

#### **Cara Thomas**

Cara did not know she was pregnant until she was nearly four months along. She was tired, but experienced no nausea or major first trimester discomfort. "I had a wonderful pregnancy!" she recalled, although it was stressful for the first few months after she and her partner learned that she was pregnant (Thomas 2011). She had always known she wanted to be a mother, but her partner, Elliott, was younger. Cara and Elliott were not even living together when they conceived, and by the time the pregnancy was known, they were already at four months! They faced a steep learning curve but she said that by six months, they had both come to terms with the situation.

Cara's "due date" came and went. She tried several different natural methods for inducing labor, but to no avail. Finally, ten days overdue, she was awake at 1:00 am when she says she felt something shift and she just knew it was time. Sure enough, labor progressed.

At the birth center, Elliott climbed into the tub with Cara and supported her the whole time. Elliott's whole family was there in the waiting room. "I think I scared his brothers," Cara recalled with a chuckle, referring to the sounds she

made (ibid.). Cara was very modest going into the process, wearing a sarong in the tub, but remembers not caring at all about modesty by the end.

Cara had worked a full shift the day before she went into labor, so she was especially tired and kept falling asleep between contractions. She was on the verge of dehydration and exhaustion. She labored for a total of twenty-two hours. Eventually, Genevieve mentioned the possibility that they might have to transfer to the hospital.

Cara did not want to go to the hospital. Shortly after discussing transfer, Cara's labor intensified. Once she hit transition, Cara pushed for a total of eight minutes and her son was born! "Genevieve had tears in her eyes," she said with pride (ibid.). Cara says she "couldn't have done it" without Genevieve's kind encouragement (ibid.).

#### Megan Boswell

Megan had a simple life on the outskirts of Fairbanks with her husband of four years, Chris. Within a year, her marriage broke up and she became pregnant by another man. She was terrified, but at thirty-four, she felt that this might be her only chance to have a child. The circumstances were less than ideal, but the father, Abe, was encouraging. They decided to have the baby and build a life together. The pair moved around the state and finally settled in Fairbanks. Megan knew she wanted a natural birth and started going to AFH&BC for prenatal care. She was eight months pregnant when one day Abe left and did not come back. Megan was embarrassed and distraught. She did not know what was going to happen. Eventually she felt she had to tell the midwives what was going on.

"Claire is so salty!" she reported with enormous relief. Claire had been unphased by Megan's revelations and very compassionate. Amidst the stress of her personal situation, Megan began to go into premature labor. The midwives advised her to go home and rest, rest, rest, which she did. She had to ask other

people to move all her belongings from where she was living to a friend's cabin closer to town. Megan was determined that her son not be born before the thirty-seven week cutoff when she could legally go to the birth center instead of the hospital. She had to go to the birth center more than once to check that she was not leaking amniotic fluid, but the test came back negative every time.

Megan's friend Moriah had been scheduled to come up to Fairbanks for the birth and Moriah's role was even more critical now that Abe was gone. Moriah was in California working, so when premature labor threatened, another friend, Anna, arranged to come. A local friend also agreed to be on call in case she went into labor before Anna arrived.

Megan and her son went passed the thirty-seven week date and into thirty-eight weeks. Anna arrived in Fairbanks. The day Anna arrived, she and Megan went to a prenatal appointment. They had the car seat properly installed at the police station and went out for Thai food. At ten o'clock that night, Megan's water broke.

Contractions started soon thereafter. Megan called to let the midwives know and set about laboring at home. She and Anna fumbled trying to time her contractions, laughing at themselves. Eventually Anna went upstairs to rest before it was time to go to the birth center. Megan said her perception of time during labor was "warped" (Boswell 2011a). She does not remember whether she listened to the birth playlist she made. "How can I *not remember*?" she asked, marveling at the state of mind the contractions induced (ibid.). Megan had wanted Abe to be present for the birth but to her surprise, she found that being alone was positive. She thinks that being alone helped her to progress much faster, not worrying about what she looked or sounded like. Around 5:00 am, Anna finally drove Megan to the birth center. Megan had no idea how far her labor had progressed. She had simply tried to labor at home as long as she could because she did not want to arrive at the birth center too early. As they crossed the overpass at Chena Pump Road, Megan vomited out the window of her car.

The next morning when she went out to her car, she saw that the midwives had cleaned the side of her Subaru.

No sooner did Megan arrive at the birth center than she suddenly felt the urge to push. Talia checked her cervix; Megan was desperately hoping that she was at least at five centimeters. “Just let me be half way,” she pleaded mentally (ibid.). In fact, she was completely dilated! Without realizing it, Megan had progressed all the way to transition on her own.

Talia filled the tub and Megan stepped in. She was glad to be in the water because the only position she could tolerate was squatting. “Thank God I was in the water! My legs would have gone numb! (ibid.).”

Megan emphasized in her interview how painful and scary pushing was for her. She had expected pushing to be less painful than dilation. She had thought that pushing meant she would have a choice—that she would feel an urge and then decide to push. Much to her surprise, she had no control over it. She said she would feel the contraction building and then before she was ready, her body would push involuntarily. “At first I was so freaked out by the pain, but then you just have to go with it,” she explained (ibid.).

Anna sat by the tub, just being present, murmuring occasionally encouragement. Talia told Anna to bring Megan some water and instead of asking Megan if she was thirsty, Anna just held out the straw and Megan drank the water between contractions. Megan appreciated the fact that nobody ever asked her a single question during labor. Having to interpret a question and then respond would have really broken her concentration, she said. She also appreciated that nobody touched her. A couple times Anna rubbed her shoulders and it felt good in between contractions, but during them touching was too much. She quietly asked Anna not to touch her during the contractions and Anna stopped.

While Megan was shocked by the pain, she said she was also able to speak calmly and directly when she needed to. This was an interesting

measuring stick for Megan. Paradoxically, while she emphasized repeatedly that labor was shockingly painful, she also said that the pain never became as bad as she expected. "I never freaked out or screamed. . .like I totally expected to," she said (ibid.). She had gone to the emergency room twice in her life before giving birth because she was in so much pain that she thought maybe her appendix was rupturing. Both times menstrual cramps had caused the pain. She had prepared herself for labor by thinking that it would be far worse than her menstrual cramps. But it never became that bad, which is why she was surprised to find that she was in transition when she arrived at the birth center. She had also expected labor to take longer. She thought she still had a full day ahead of her when she arrived at AFH&BC. Instead, after arriving around 5:30 am, she pushed for a little over two hours and her little boy's head emerged. To Megan it seemed as though an eternity passed before another contraction pushed out his body, but it was just after 7:30 am.

Megan had feared that she would spend the whole labor feeling sad and angry about Abe. To her relief, she was completely consumed by the birthing process. She and her baby enjoyed skin-to-skin bonding time after the birth, which was very important to her. They rested together for several hours until they were ready to go home.

The midwives took the final round of vital signs before departure. Rowan's breathing, which had been slightly stressed at first but then improved, had become stressed again. Talia conferred with Claire. After checking the oxygen level in his blood, Claire decided that Rowan needed to go to the hospital. Megan was upset, but she appreciated the clear and professional manner with which Claire communicated the need for transport.

Initially, Megan thought she would have to go to the hospital alone but Talia accompanied them. Megan was very grateful for this. She said that Talia was calm and clear, even when the woman running the check-in desk at the emergency room was disorganized and slow. Megan said that Talia knew all the



right instructions to give, for example, about Megan's preference to breastfeed. Even though check-in was difficult, once they arrived in the maternity ward the attending pediatrician was very competent and respectful. Rowan did not need antibiotics, and the doctor did not automatically prescribe them, which was a relief to Megan. Megan was given a room to stay in, meals, and a breast-pump. The nurses regularly brought Rowan in for feedings, even during the middle of the night. Rowan thrived and within only a few days he was released from the hospital.

At the beginning of Claire's interview, one of the first questions she asked was whether Megan was going to be in the study. Claire said she thought that Megan's story was important. Imperfect circumstances like abandonment and transport are part of birth, she explained. Claire also appreciated the community support upon which Megan was able to draw when her circumstances went awry.

#### Lena Fischer

Lena told a seemingly short, happy birth story. Her son was born after only about five hours of active labor. "It went from zero to a hundred and eighty!" she remembered.

As the interview progressed, however, it became clear that the birth was actually more complicated. Lena was in the tub laboring when her son began having what are known as decelerations. This is when the baby's heart rate drops during contractions because the blood flow is restricted for some reason. Decelerations are one indication of fetal distress and can be mild or severe, depending on how low the heart rate drops and for how long. The midwives had Lena climb out of the tub. The baby needed to be born as soon as possible. He had a large head and just as he was about to exit the birth canal this delayed his emergence. Normally the midwives would allow Lena's body to stretch slowly and naturally, but in light of the decelerations, they decided that an episiotomy was appropriate and thus Lena's healthy baby boy was born.

This technical outline of events is the researcher's reconstruction of what occurred; however, this is not how Lena recalled her birth. The way that she tells her story is brief and genuinely joyful. This was fascinating because despite the serious complications involved, Lena seems to have no lasting pain, fear, doubt, confusion, anger, or trauma surrounding her birth, as so many women do. Lena seems proud that her body was able to labor so quickly. She took the process one step at a time, facing each step openly and responding to each challenge as it arose. "Don't resist it," she advised, "It'll hurt" (Fischer 2011).

Lena said the most helpful advice anybody gave her beforehand was a comment during the childbirth preparation class that going into a meditative state during labor can help. Lena had no background or training in meditation practice. However, the teachings of meditation seem an apt description for the way she lives her life. The meditative state came to her naturally during labor and she admitted that one of the most frustrating things anyone did was to walk between her and her visual point of focus. In front of her was an oxygen tank with a sign bearing the chemical symbol for oxygen. The symbol was familiar and it just happened to be there, so she stared at it. Lena also said that her doula's touching her during contractions was distracting and Lena had to ask her to stop.

When asked if there was a religion with which she identified, Lena paused, looked at her husband and shrugged, "Christian?" (ibid.). When asked if there is a spiritual aspect to birth, she considered the question for a moment and said simply, "No" (ibid.). When asked if she thinks that thoughts and emotions play a part in the labor process she chuckled, "Not if you're really in labor!" (ibid.). When asked why she chose AFH&BC she says that she had a friend who used midwives and she liked that approach. "I don't really like doctors," she said. At the hospital, "there's too much going on for the simple act of giving birth" (ibid.).

She and her partner are eating lunch during our interview: Wendy's French fries and shakes. We sit in a conference room at the environmental consulting firm where she works. Lena says her scientific background does not

play a significant role in her choices about birth. She says she did not do very much research before the birth; she just “went with it” (ibid.). That is the plan for her upcoming birth as well, for which she is again receiving prenatal care at AFH&BC. She is twenty-two weeks along. She hopes that the next birth goes just as well as her son’s did.

The one thing she wishes that she would have done differently was stay at the birth center a little longer to make sure that she and her son had established breastfeeding. They went home quickly after his birth and were never able to breastfeed successfully, despite a visit from a lactation consultant. She hopes to breastfeed her next baby.

#### Olivia Scott

Olivia is a mother of five who had her last baby at AFH&BC. She has experienced a wide spectrum of birth practices, from those at a standard American hospital in Minnesota, to a military hospital in Kentucky, to a home birth in Minnesota, and finally the birth center in Fairbanks. She has also been a La Leche League leader for eight years and is now an International Board Certified Lactation Consultant.

Liv has always had very fast labors. Her fourth child was born twenty-five minutes after the first contraction. Having four children, she did not have time to process the emotions generated by such a rapid labor and birth.

When Liv learned she was pregnant for the fifth time, she was excited. Her husband, Troy, who is in the military, was going to be home for the birth. She was also excited to have a baby in Alaska because birth seemed to be so positive in Fairbanks. As a lactation consultant, she did not receive nearly as many phone calls for help as she had in other parts of the country where she had lived. Most of the calls she did receive were from military families who had

delivered their babies on the base.<sup>17</sup> Liv was supposed to deliver her baby “on post” as well, but because of their family size, she qualified for Denali KidCare and was able to use the birth center.

When the big day came, instead of a twenty-five-minute event, Liv found herself having slow labor for the first time in her life. It was not painful. She was simply experiencing sporadic contractions that did not seem to be progressing. “I was having an ecstatic birth,” she said in retrospect (Scott 2012). She called the birth center to consult with the midwives and they decided to have her come in to be checked.

Once there, the midwives determined that she was in labor and that she was dilating even though labor was not progressing in ways that she was used to. Liv and Troy considered going home, but it was a half-hour drive to North Pole and Liv was nervous about having a baby on the side of the highway. Despite the fact that they had planned a home birth, they decided to stay the night at the birth center. Taking the situation in stride, Liv said, “Well, I’ll have a water birth!” which she had never done before (ibid.).

At that time there was a visiting midwife named Jen helping out at the birth center. Jen filled the tub and Liv stepped in. Jen talked with Liv and asked her questions. Liv realized that she had fears from her last birth that she had not only not resolved, but of which she had not even been aware. “I think I might have died,” she said in her interview. This sensation was not from pain or fear. It seems to have been a more literal sense of absence. “There is no way to describe what it is like to open to ten centimeters in twenty-five minutes” (ibid.).

After talking with Jen, Liv felt better. Then, all of a sudden, she said she felt Declan turn. “I’d read that in birth stories before but I had never experienced it,” she said (ibid.). She felt him turn, and suddenly she thought, “I wonder if I should push?” (ibid.). This was not an uncontrollable urge to push, and it did not

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<sup>17</sup> There are Certified Nurse-Midwives and water birth is allowed at the military hospital in Fairbanks, but there are no lactation consultants according to Olivia (February 2012).

seem that she could possibly be that far along in her labor. Where was the *labor* in her labor? She gave a little squeeze, and Declan's head started to emerge.

Liv recalled in her interview how she felt his head crowning with her hands. She had never done that before. It had never occurred to her to touch her emerging child and nobody had ever suggested it. Then he was born. Troy and all of their older children were in the room, but everyone was quiet, she remembered. Nobody was talking. Peace came over her face and in her voice as she recounted the scene during her interview. Liv and her family drove home a few hours later. It was nearly midnight, but the summer sky was still light.

## 5.2 Postpartum Care

As for postpartum care, the midwives do not administer vaccines, give vitamin K shots, or put antibiotic ointment in infants' eyes following birth.<sup>18</sup> Immediate skin-to-skin contact is normal, as is delayed cord clamping (Hutton and Hassan 2007; World Health Organization 2003, 7). Each birth is attended by two midwives, and when the time comes, the two who are on call will attend. After the birth, one midwife does what is called "the 24-hour" visit. She goes to the family's home and checks on the infant's weight, heart rate and breathing, breastfeeding, and the mother's blood pressure and recovery. She also asks if the family has any general questions or concerns. At one, two, and six weeks after the birth, mother and baby return to the birth center for checkups and information regarding contraceptive options. An informal postpartum support group has also been started by a local doula and all families are welcome to attend.

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<sup>18</sup> With regard to the antibiotic ointment, STD screenings are offered to all mothers as a routine part of prenatal care.

### 5.3 Conclusions about Intrapartum Care

Cara's and Liv's birth stories both show the value of having a trusting relationship with the midwives. Megan's story demonstrates the emphasis that is placed upon privacy and "going deep" in birth at AFH&BC. Lena's story demonstrates the attitude that midwives do not control birth but observe and respond accordingly to achieve good outcomes. In each case above, the egalitarian nature of the relationship between the midwives and the parents is evident. These stories clearly demonstrate how the process of birth integrates physical, psychological, and social well-being. All four of the stories are very different in the way that they unfolded and in the amount of time that elapsed during labor. This shows how the AFH&BC midwives normalize uniqueness and allow the natural physiological process to unfold with positive support and minimal intervention.

## Chapter 6: The Physiological Process

I like helping moms and babies. I like being a guardian of birth. I like to witness the awesome power of a woman and the . . . exquisite part of bonding and attaching to a baby, and a baby to a mom, at birth. I like giving families a choice in where they have their babies, and I don't think the hospital is a place where people should have babies if they're healthy. . . . Because I don't think there is that awareness of what is actually happening. It's a medical procedure that usually needs, as far as they're concerned, needs to be managed and controlled.

Genevieve Reid, November 2011

How a culture understands a passage informs its response. The midwifery model of care understands the physiological process of birth as healthy physiological functions. Midwives navigate this process by focusing on the role of hormones, by defining progress in ways that are realistic for unmedicated labor, and by having a pragmatic approach to obstetrical complications.

### 6.1 Emotions and Hormones

This chapter will examine what is meant by “the natural, physiological process” according to AFH&BC culture and how this understanding is holistic. The role of emotions and mental processes is a defining aspect of the midwifery model of care. Midwives cater a great deal to the emotions and mental concerns of parents. Yet, in interviews, both midwife and mother respondents stated that birth is a physiological process and that emotions do not matter if a woman is truly in labor.

Emotions are part of the physiological process. Hormones are the mechanism that unites the body with the emotions. Some feelings that are expressed outwardly as emotions can be expressed inwardly as hormones, and it turns out that these hormones can have a direct impact on the birth process. This is especially true in early labor when the cervix is still effacing and dilating. Therefore, smoothing out the emotions can help smooth out the physiological process.

Oxytocin stimulates uterine contractions that aid labor and help to stop postpartum hemorrhaging (Impey and Child 2012, 243). Mainstream maternity care demonstrates this by using Pitocin, which is synthetic oxytocin, to induce and augment labor. The body naturally produces oxytocin when a person feels safe and loved. Endorphins are, among other things, a natural painkiller that can help a mother to cope with labor (Jowitt and Kirkham 2012). Adrenaline counteracts oxytocin, thereby slowing and sometimes stalling labor. Adrenaline is produced in response to fear (Impey and Child 2012, 247). The midwives at AFH&BC understand birth as a holistic process that includes psychological, mental, social, and physical well-being. Hormones, and therefore emotions, are an integral part of the birth process, facilitating physiological outcomes using non-physical methods.

Fear can be especially powerful. Deb cited Pam England and Rob Horowitz's *Birthing From Within*, explaining that even if a fear is not realistic, it can still impact the physiological process. "If a deer sees a tiger while she's giving birth in the wild, she's going to run! And that's going to be the case whether it really is a tiger or it's just a shadow. If the deer believes it's real then the outcome is the same. So what are our tigers? Even paper tigers can bite" (Donnan 2011b; England and Horowitz 1998, 118).

While it is important to acknowledge the role that emotions can play, Talia pointed out that emotions are not the only factor in birth. Emotions can hinder the process, especially in early labor, but emotions alone cannot stop birth. Talia



compared birthing to death in the sense that “being scared doesn’t keep us from dying” (Schaefer 2011), nor does it prevent a woman from birthing. A woman cannot remain pregnant forever. The point is that by creating a safe, comforting environment, the midwives are facilitating the optimal performance of the natural, physiological process.

Having birthed in frightening and traumatic conditions more than once, Liv also pointed out in her interview that birth still happens even when a mother is scared. However, she adds that how a woman enters motherhood affects how she goes on to parent. Hormones play a significant role in breastfeeding and bonding (Jowitt and Kirkham, 2012). Liv has seen that interrupting those hormones can contribute to difficulties with breastfeeding and bonding, the effects of which ripple outward into life long after the birth itself is over. Therefore, according to Liv, how and where to give birth is not just a “red shirt or blue shirt today” decision (February 2012). For her, the decision of where to birth is “about the atmosphere in which we live our lives” (February 2012).

## 6.2 “Going Deep Within”

Another contraction would hit me and I instantly was transported into my own world—that crazy labour land where pain is the focus and thoughts the distraction. Where all that is going on around you is plainly visible, but easily unseen. Where your inner voice is sane and reasonable, but your spoken words are unintelligible and irrational. Labour land is really like no other. It is all fuzzy with crystals of clarity. It is forgettable while spiked with fleeting and often indifferent moments seared into memory. It is on a different plane entirely. I felt myself diving down, surfing toward, and settling into that plane more and more with every contraction.

“The Birth Story of Ava Lilly” (Birth Without Fear 2011)

The midwives at AFH&BC encourage mothers to focus inward during labor and birth. In fact, the midwives consider facilitating this state to be one of the most effective strategies for working with the body's complex birthing process. Giving a mother privacy and allowing a mother to focus without talking or touching can help her to "go deep within."

In their experience, the midwives report that going deep is a natural way of coping with the pain. It does not take the pain away but makes it more manageable. This mental state is not induced by the midwife. It occurs naturally. The midwife can only encourage it by providing conditions that are conducive to it. When asked what role the midwife plays in facilitating this, Deb explained that the more births the midwives attend, the more hands-off they become. "The longer we've done it, the more hands-off we get; the more we tend to give moms privacy and space, and not feel like we have to rush in and do things all the time (Donnan 2011b). She adds that of course there are times when it is appropriate to be "hands-on," but more often she finds privacy to be more effective. Often a mother simply needs to have room to let her body do what it needs to do. She reports that this perspective has evolved over the years amongst the midwives at AFH&BC. She adds that "Younger midwives tend to think they're doing it. . . . the success for them, is when the mom has a successful birth because they did everything. . . . We don't feel that way. We really feel the opposite where we give the mom space to do her thing and things are going to go better" (ibid.).

### 6.3 Authoritative Knowledge: The Knowledge

The orientation toward authoritative knowledge is another defining characteristic of the midwifery model of care. This section will analyze the concept of authority with respect to knowledge. What constitutes information and what sources are considered legitimate?

The midwives at AFH&BC use several types and sources of information. Observations are made directly with eyes, hands, and ears. For example, vaginal

exams are used to gauge cervical dilation. The woman's body language, voice, and breath can also be significant sources of information. Observations are also made indirectly through instruments. Stethoscopes, ultrasounds, and prenatal laboratory testing are good examples of technologies that AFH&BC midwives use to obtain information, although these technologies are used in a more limited capacity than in mainstream prenatal care.

Mothers are also a very important source of information in the birth process at AFH&BC. For example, instead of watching a monitor that beeps to measure the timing and duration of contractions, midwives watch the mother. The sounds that a woman is making can tell midwives much about how far along she is in labor, regardless of how many hours she has been in labor or how close together her contractions are.

The mother is a source of information, but she is also a person who has legitimate access to information and the authority to assert it. The mother has a lifetime of experience in her own body and approximately nine months of experience with her baby. The mother's knowledge about the pregnancy and birth is respected, supported, and encouraged.

Intuition is another source of information that midwives use. Claire noted this during her interview. It is something that cannot be taught, she said, but that is honed through experience, inclination, and practice. Intuition is explicitly mentioned on the MANA website within the "Statement of Values and Ethics" (2010):

We value the wisdom of midwifery, an expertise that incorporates theoretical and embodied knowledge, clinical skills, deep listening, intuitive judgment, spiritual awareness and personal experience.

Personal experience helps to inform both midwives and their clients. For clients, social networks and the experiences of acquaintances are also sources of information that are valued, according to participants. At least five of the six

participants knew other people who were using or had previously used the birth center.

Once information is obtained, how it is analyzed is equally significant in assessing its meaning. Betty-Anne Daviss, in an article (1997) about midwifery care amongst indigenous people in Canada, noted that different people observing the same situation analyze it using different frameworks. She cited eight different systems of logic frequently used in birth: scientific logic, clinical logic, personal logic, cultural logic, intuitive logic, political logic, legal logic, and economic logic (Daviss 1997, 443-444). Daviss briefly describes each type of logic:

*Scientific logic* is based on evidence, not only from biology and physics but from available epidemiologic knowledge—that is, from statistical analysis of health and disease or normalcy and risk patterns in birth.

*Clinical logic* is used by healthcare practitioners to assess the health and determine the treatment of the mother and baby at the office, home, or hospital visit. It varies according to the training, experience, knowledge, philosophy, and peer pressure of the practitioner dealing with the case. Unfortunately, it is sometimes presented by practitioners as, or assumed by their patients to be, scientific logic, even when there are no statistics or trials to back it up.

*Personal logic* is used when individuals and families make decisions about what they stand to lose or gain on a personal level from their birth plans and compromises. This also includes the personal logic of practitioners, whose careers may be positively or negatively affected by particular healthcare decisions.

*Cultural logic* is concerned with the development or demise of fundamental beliefs about how a given society should manage

birth. This category can include traditional community logic and spiritual logic.

*Intuitive logic* is based on information directly apprehended by a person who has the ability to become familiar with and make decisions about a situation without necessarily depending on other forms of logic. Some people have more of this intuitive ability than others. I consider cultural logic to be a kind of common sense, and intuitive logic to be a kind of uncommon sense.

*Political logic* assesses the projected consequences of what will be said and done about birth plans and birth outcome by family, community, “public opinion,” peers, other practitioners, and government policy makers. It is concerned with issues of who has the power to control childbirth and of what cultural institutions and values will be reinforced and perpetuated through that control.

*Legal logic* is based on concerns about liability should anything go wrong during the pregnancy or birth. Even though the notion of “informed consent” grew out of legal logic, it tends to undervalue “informed choice,” as court battles are usually conducted by legal and professional experts, and lay opinion does not carry much weight. Legal logic—read ‘fear of liability’—is often the deep underlying basis for decisions made by birth practitioners.

*Economic logic* has to do with assessing cost benefits and risks. It is applied differentially, depending on whether one’s goal is to save or to make money from a given birth (Daviss 1997, 443-444).

The systems of logic that Daviss identifies play an enormous role in the validation of knowledge and explain why the obstetric model of care and the midwifery model of care can exist parallel to each other and both be valid. The

midwives and clients at AFH&BC use biomedical information in the context of a holistic epistemology.

#### 6.4 Conclusion

The midwives help their clients to navigate the transformation of pregnancy, birth, and the postpartum period by having a positive, holistic view of the natural, physiological process. This philosophy is reflected in the effort that the midwives put into facilitating the mother's own hormone production by supporting her emotionally. This practice is holistic, embracing physiological, psychological, and social well-being. It promotes a positive view of the natural process by prioritizing a mother's own hormones over synthetic hormones which could easily be injected. These practices demonstrate trust in the natural process and a woman's body as an expression of that natural process. By enacting this culture during the affective time during birth, the initiates in this rite of passage are receiving the culture and understanding themselves in their new role in society.

## **Chapter 7: Failure to Progress**

### **7.1 Preventing Failure to Progress**

Having examined how the natural, physiological process of birth is understood within the culture of AFH&BC, now it is possible to turn analysis to how this philosophy is applied as practices that support and facilitate the physiological process. Specifically, how do the midwives at AFH&BC address failure to progress?

Failure to progress is one of the most common diagnoses leading to a cesarean (Barber et al. 2011, 29; Rooks 1997, 274; Wagner 2006 39-40). It is also one of the most common reasons for intrapartum transfer to the hospital from AFH&BC. Therefore, addressing failure to progress is a significant part of care at the birth center. This is accomplished in three ways: by preventing failure to progress altogether, by defining “progress” in a way that is consistent with unmedicated labor patterns, and by using natural techniques to help the woman continue progressing if labor does slow down or stop.

During prenatal care, the midwives closely monitor the baby’s position externally via palpation with their hands. Fetal position was cited by the midwives as one of the most common reasons for failure to progress. They say that good exercise and posture during pregnancy can help keep the baby in a good position and the midwives provide mothers with recommendations about how to accomplish this.

Helping the mother to feel safe leading up to and during the birth is very important because it decreases fear going into the birth. As the previous chapter explained, fear releases hormones into the woman’s system which can hinder labor (Impey and Child 2012, 247). The midwives help the mother to feel safe by developing a trusting relationship with her during prenatal care. The midwives demonstrate their model of care during these interactions, speaking and touching

conscientiously, acknowledging the family's concerns and answering questions. This is why the prenatal appointments frequently last an hour or more.

Once active labor commences, the woman is in a familiar environment amongst familiar people. Talking and touching are kept to a minimum. When needed, talking is quiet. Touching is very conscientious, for example, by providing counter pressure on the woman's back. Lighting is kept dim. These measures help to reduce fear and distraction.

The mother is able to walk and move at will during labor. The midwives explain that walking allows helps the mother to manage the pain and helps the baby to move into a good position as he or she descends into the birth canal. Studies have shown that labor was shortened and epidurals were less frequent when women were allowed to walk and assigned to an upright position for the first stage of labor (Dowswell et al. 2009). For the birth itself, being on her back is shown to make the pelvis smaller and therefore to hinder delivery (Impey and Child 2012, 246).

Staying hydrated is very important (Impey and Child 2012, 246). AFH&BC others eat and drink at their own discretion.

Vaginal exams to check cervical dilation are kept to a minimum. Most of the time a check will be performed upon arrival at the birth center or arrival of the midwives at the mother's home. Checks occur approximately every four hours after that as needed, or upon the request of the mother. Another check is frequently performed at the beginning of the pushing phase to ensure that there is not a lip of cervix that will prevent the baby from passing through.

All of the midwives cited privacy during labor as being paramount for optimal birth. Talia even stated that as a broad generalization, time could be added to labor for each additional person present. As stated above, during early labor Megan was alone on the main floor of her house with her friend Anna upstairs, available to help if needed. Although before labor began, Megan had wanted the father to be present, afterwards she reported that she thinks being



alone in the room helped her to progress more quickly because she was more able to focus and to do whatever she felt compelled to do in order to deal with the pain, without having to consider how she looked or sounded. When Megan arrived at the birth center she was already beginning the pushing phase of her labor.

The emphasis on privacy at AFH&BC initially seems to differ from the practices of many other midwives and birth centers. The value of continuous care and emotional support during labor and birth are one of the four points stated in the Midwives Model of Care according to MANA (Midwives Alliance of North America 2012). A 2012 study found that women had higher rates of spontaneous vaginal birth, shorter labors, lower rates of intervention, lower rates of pain medication, and higher rates of satisfaction with the continuous support of a nurse or midwife, a doula, or a person of her choosing such as the father, a friend, or family member (Gates et al. 2012). When asked how the midwives balance privacy with the need for emotional support, Deb stated that the father or birth partner often provides most of the emotional support during labor. However, Deb explained that if a woman does not have labor support or her support partner is hindering her process in some way, one of the midwives will then serve in that capacity. At times, the midwives also talk to the support person and help him or her to be more effective support for the mother. This can be difficult if the support person is afraid of OOH birth. If the mother has to defend her birth choices from the person who is there as her support, then her focus is distracted. In her receptive, liminal state, those fears can easily transfer to her and make labor longer and more painful. That is why birth partners are encouraged to attend the birth preparation class and prenatal appointments with expectant mothers, so that they too can develop a positive relationship with the midwives and all can work together as a team when the time comes for the birth.

While there is significant emphasis on privacy, as the above birth stories demonstrate, it is very common for family members, older children, and other

friends to attend births at AFH&BC. This is left to the mother's discretion. There is a room in which family members can wait during labor if they wish to be present but not in the birthing room itself.

When strong, active labor has been ongoing for many hours with no further dilation, the midwives use a number of natural techniques to revive it. Often the first suggestion the midwives will make is for the mother to change position or move around, walking or swaying. Talia reported that simply "changing things up" can help a surprising amount of the time. One option that works well is sitting on the toilet, which both changes the mother's position and enhances the feeling of privacy. Nipple stimulation releases natural oxytocin into the woman's system which stimulates contractions (Wagner 2006, 41). If the woman is too tense, the midwives report that entering the tub of warm water can dramatically help a woman relax. Conversely, stepping out of the tub can speed labor if the woman is too relaxed. There are also times when the body simply needs a rest. Talia said this is not uncommon just before the pushing phase. A short nap can rejuvenate a mother and allow her to push when she wakes up.

As stated before, the midwives emphasized keeping the mother hydrated. Deb reported that in the last few years AFH&BC midwives have been able to administer hydration intravenously when necessary, and this has been a useful tool.

Talking with the mother can also help as in the stories of Cara and Olivia. As chapter six explained, strong feelings, especially fear, can trigger hormones that have a physiological impact on the birth process.

## 7.2 Defining Progress

A significant factor in preventing failure to progress is how one defines "progress." The midwives at AFH&BC do not use Friedman's Curve in order to judge progress, which sets the average rate of dilation at 1-1.2 cm per hour (Rooks 1997, 318). In practice, unmedicated labor varies widely from woman to

woman, or even baby to baby for the same woman. Labor does not usually progress at a smooth, consistent rate. It often moves in jumps and starts, and the cervix can even contract after being previously dilated (Gaskin 2011, 29-31). Colloquially, many women have begun replacing the term “failure to progress” with “failure to wait.” As Judith Pence Rooks has written, midwives tend to focus on the normal rather than the pathological (Rooks 1997, 126). Observing the same phenomenon, Robbie Davis-Floyd coined the phrase “normalizing uniqueness” (Davis-Floyd, 2011). Instead of holding mothers to artificial or unrealistic standards, the midwives see a very broad spectrum of ways that birth can work and allow women to find their own place on that spectrum, keeping watch for indications of specific threats.

In preparing clients for birth, the midwives emphasize the distinction between early labor and active labor. Early labor can start and stop many times. It can last for days, or sometimes even weeks, before the actual birth takes place. The cervix is ripening, effacing, and often dilating, even when the birth is not immediately imminent. In the midwives’ experience, early labor is more easily interrupted. Labor often stalls when the woman changes location and is surrounded by new people and activity. During the birth preparation class, Deb stresses that a woman should labor at home until she has a well-established pattern of active labor because in their experience, a well-established pattern of active labor is less likely to stall from the interruption. Of course, driving to the birth center is not an issue for the 20 percent of AFH&BC clients who give birth at home; however they must understand when birth is imminent and when to call the midwives.

The midwives pay attention to the passage of time; however they do not judge progress by time alone. Sometimes, they report, progress is very slow, but that is still progress. As long as the mother and baby still have strong vital signs then the midwives allow them to proceed at their own pace. It is worth noting that a clock does start ticking, with the rupture of membranes. If labor has not

commenced within twenty-four hours of the water breaking the mother must be transferred to the hospital due to increased risk of infection. The midwives reported that this is rarely an issue. If contractions did not precede the water breaking, contractions usually begin shortly thereafter. The membranes may rupture at any time during birth, from before the onset of early labor to the very end. Occasionally infants are even born “in the caul,” in an intact bag of waters.

Often mothers are unsure if what they are experiencing is early labor or active labor. The midwives are always available to answer questions over the phone or to have people come in to the birth center to confer and be checked. The midwives stress that allowing labor to progress undisturbed and unhurried prevents most cases of “failure to progress” and the need for intervention as a result.

### 7.3 Authoritative Knowledge: The Authority

Multiple times during her interviews Talia stated that birth is “just a physiological process” (Schaefer 2011). This was initially puzzling considering how much time midwives devote to women’s feelings. Over time it became clear that one of the points she was trying to make was that low-risk births by healthy women do not require special training or esoteric knowledge. From her perspective, the body innately knows how to birth, just as it grows the baby. In that sense, birth is an involuntary physiological function, like digestion.

While the midwives have years of training and experience in birth, they emphasize listening to the mothers. As discussed in previous chapters, the relationship between the midwives and the clients at AFH&BC is not hierarchical, with midwives telling clients what they are and are not allowed to do.

Liv especially appreciated this approach. In three of her four previous births, she felt that her knowledge was not respected. Many times she was not given the opportunity to provide informed consent, and the doctors and nurses performed procedures to which she objected. With her oldest child Liv was told

not to push until the doctor came. Ultimately, her daughter emerged before the doctor arrived. Olivia vividly recalled the birth: “I held that baby in my birth canal for half an hour waiting for the doctor to show up and [the nurse] ended up getting in trouble for catching her!” (February 2012). Having had three hospital births, she felt that the hospital staff would “walk all over” her if she let them and that she had to protect herself and her baby from them (February 2012). At AFH&BC, “I didn’t have to be the mama bear. I didn’t have to have a birth plan to hang up, or a big sign on my forehead. They just let me do it” (February 2012).

During her last pregnancy, Liv knew when she had conceived but “I made the mistake of telling them the date of my last menstrual period,” she said, referring to the military doctors who started her prenatal care. A dating ultrasound confirmed that she was correct, but they used the date of her period to perform the calculations on her lab tests. When the results came in, she was rejected as a patient at the birth center because the results incorrectly placed her beyond the risk threshold. Liv had to call the testing company and request that they recalculate her test based on the correct date. Once the new results were received, she was accepted as a client at AFH&BC and went on to have a happy, healthy birth. Liv concluded, “The midwives respected the fact that I’d already had four babies, and that I’ve read and worked with other women. Most OBs, it’s like *they* get defensive if they know you’re educated” (February 2012).

The mothers in the study exhibited a lack of trust in the medical establishment with regard to birth. Cara said, “I guess I’ve never had good experiences in the medical world” (Thomas 2011). Lena reported: “I don’t really like doctors” (Fischer 2011). Sienna called obstetrics “unquestioned” and compared it to 9/11 (Carter 2011). Sienna perceived the dominant narratives surrounding both maternity care and 9/11 to be blatantly inaccurate despite their accepted status in society. Sienna is the youngest mother in the study. She was about twelve years old when 9/11 happened. It was telling to hear someone so young express such distrust in the nation’s dominant institutions so openly.

However all of the mothers expressed some level of distrust of the dominant institutions in American culture.

The participants did not wholly reject the medical model of care, but they clearly did not accept the medical establishment as having exclusive authority over birth. While trust in standard medical care for birth was low, participants expressed a high degree of trust in the natural physiological process and/or their body's ability to birth. The word "natural" is ubiquitous in the OOH birth field. Lena stated that "Our bodies have been doing this for thousands of years" (Fischer 2011), an idea that Talia and Claire both expressed as well. Sienna shared this sentiment, stating that, "My body was made to do this" (Carter 2011).

The humility and egalitarianism that are characteristic of the midwife-mother relationship extend to the interactions between the midwives as well. Talia is extremely deferential to her older mentors, valuing their knowledge and experience very openly. "I'm just a baby midwife" she says, "I'm still learning so much" (Schaefer 2011). She expressed this deference during interviews and participant observation, as well as practicing it by conferring with them frequently. Deb also demonstrated this humility. When asked at the start of her interview how many babies she had caught, Deb was quick to clarify that she had attended around seven hundred births but she did not know who had done the actual "catching;" she would have to go back and look at each of the charts. The midwives do not distinguish who actually catches the baby, only who was in attendance at a birth. This emphasis on egalitarianism and humility during the transformative process of pregnancy and birth resembles the anti-structure of Victor Turner's *communitas*.

#### 7.4 Conclusion

How do the midwives at AFH&BC address failure to progress during birth? The midwives at AFH&BC employ a positive, holistic view of the physiological process of birth. With that as their philosophical starting point, the midwives strive

through their practices to provide conditions for the natural process to unfold in the smoothest possible way and then allow it to work on its own. In most cases, failure to progress is simply avoided. The midwives reject of Friedman's curve in favor of more individualized timing. When labor does stall, the midwives use a number of techniques to encourage it such as movement and hydration. The relationship between the parents and the midwives is markedly egalitarian, as is the relationship among the midwives. AFH&BC culture is non-hierarchical in structure.

## **Chapter 8: AFH&BC and Fairbanks Memorial Hospital**

The dichotomy that exists between midwifery and obstetrics in the United States does not need to be as wide or contentious as it is. Midwives and obstetricians can work together using technology in the service of people when it is called for, as they do in many developed countries. As the following chapter illustrates, there is a relatively high degree of cooperation between AFH&BC and Fairbanks Memorial Hospital (FMH). Jane's birth story is a good example of the type of cooperation that is possible.

### **8.1 Jane's Birth Story**

Jane had had one very positive hospital birth in British Columbia and two previous home births with AFH&BC. She described herself as a veritable poster child of home birth and referred to the midwives as friends. When she and her husband decided to have another baby, Jane intended to have another home birth. She was looking forward to sharing the experience with her daughter. She wanted her daughter to grow up with a positive view of birth and the human body.

At twenty weeks, Jane began to bleed. An ultrasound revealed that her placenta was covering her cervix, a condition called placenta previa. The midwives reassured her that often placenta previa corrects itself. As the pregnancy progresses, the uterus expands and the placenta rides up the sidewall of the uterus and away from the cervix. However, if the placenta does not rise away from the cervix, placenta previa is a life-threatening condition.

Both Jane and her husband, Todd, have master's degrees from a seminary in Vancouver, British Columbia. They sent out a prayer request and friends all around the world were keeping Jane in their thoughts and praying for her. Jane is also very well known in the Fairbanks birth community and she received much support locally as well. Jane said the outpouring of well wishes



was truly inspiring. She never felt so loved in all her life. Jane continued to have ultrasounds to monitor her condition and yet, as time went on, her placenta remained squarely over her cervix. Faced with the prospect of a scheduled cesarean, Jane was devastated.

The midwives talked at length with her about it, helping her to understand that she had done nothing wrong. Jane talked about a day when she went to the birth center, after her care had already been transferred to an obstetrician (OB). The midwives were attending a laboring woman in the other room but the birth was not imminent and one of them sat down to talk with Jane. The fact that she took the time to do this meant a lot to her.

In her interview, Jane recounted that at some point, somebody told her that, "The ideal cesarean rate is not zero." There are times when a cesarean is appropriate and life-saving, and this was one of them. This quotation really helped Jane come to terms with her circumstances.

She did some research and selected an obstetrician with a very good reputation and a low infection rate. Interestingly, Jane's husband Todd works at the hospital as a computer programmer and her sister works there as a labor and delivery nurse. Jane asked if her sister could be in the room during the cesarean, not as a nurse but as Jane's support. Her OB said that she had to ask the anesthesiologist, which she did, and the anesthesiologist said yes. Her sister was allowed in the room.

At thirty-five weeks, Jane's OB said she wanted to schedule the cesarean for the next day. Jane was horrified. She pleaded for more time. The OB said she would wait until over the weekend, but that Jane's condition merited immediate attention. Waiting over the weekend put Jane's baby into thirty-six weeks of gestation. This would give her brain and lungs every hour of development possible.

When the day finally came for her cesarean, part of the medical procedure involved sitting in a silent room by herself and she was given a newspaper to

pass the time. In it she stumbled upon the obituary of a friend, and it happened to be his birthday. She had heard of his passing but had not realized that her daughter was going to be born on his birthday.

Jane and her sister entered the operating room and the procedure began. Jane commented on how different cesarean birth is from labor in terms of how fast it is. After the doctor lifted her baby out, Jane did hemorrhage significantly, despite having a very skilled and careful surgical team. Jane's sister remained calm through the entire procedure, and Jane assumed everything must be fine, taking her cues from her sister. It was only later that Jane realized how much she was bleeding.

Efforts were made to ensure that the birth was as gentle as possible. Todd was allowed to hold their daughter and he put her on Jane's chest. At one point the pediatrician said he wanted to take the baby up to the NICU but Todd pointed out that by then it had been an hour since the birth and they had not yet tried breastfeeding. The doctor agreed to let the baby try nursing and after that she did not need to go to the NICU.

The nurses who took care of Jane and her baby after the surgery knew that Jane had had previous home births. Jane appreciated that the nurses did not express any hostility about her previous birthing choices. In fact, they were sensitive to how difficult the transition to a scheduled cesarean must have been for Jane. Jane was quite touched by this. She said she would like to think that the treatment she received was not because of her family who worked at the hospital but that they would treat every woman like that.

## 8.2 The Relationship Between AFH&BC and Fairbanks Memorial Hospital

Claire and the other midwives have worked hard to cultivate a good relationship with Fairbanks Memorial Hospital. When asked why the hospital and the birth center have such a good rapport, the midwives reported twenty-five years of consistent care. "We refer appropriately," said Claire (Taylor 2011). It

was not always a good relationship explained Talia. “For a long time things were really difficult between them and no one really trusted that [Claire] was competent” (Schaefer 2011). The hospital staff did not know about the regulations, licensure, education requirements, or the philosophy of direct-entry midwifery. Talia thinks most of this change was brought about over the course of time and experience, as well as informal education and networking within the community. Deb noted that it also helps that all of the midwives at AFH&BC have been in the Fairbanks community for decades (Donnan 2011b).

Having a good relationship makes it easier to transport and this is an important factor in the quality of care for AFH&BC clients. Talia acknowledged that, “A lot of midwives work in areas where they are scared to transport because of how it will affect the care that their clients receive when they get there” (Schaefer 2011). In the national context, it is not uncommon for hospital staff to treat OOH midwives and their clients badly, sometimes to the point of hostility. “Also, some midwives are in places where they are practicing illegally. All that affects how you feel when you have to take someone to the hospital. It’s already hard enough to have to transport,” Talia elaborated (ibid.). The OOH birth community in Fairbanks is well established at this point and able to practice with good hospital backup.

The practices at FMH span a wide spectrum in terms of the medicalization of birth and it is the attending obstetrician or CNM who sets the tone for a woman’s care. During the course of this research, I encountered women who had had negative birth experiences at FMH. Nevertheless, the labor and delivery nurses were familiar with practices such as exclusive breastfeeding and delayed cord clamping. One speaker from the 2011 AFH&BC fundraiser said that practices at the birth center have impacted practices at the hospital.

Jane was devastated by the prospect of a planned cesarean birth, but the midwives were a tremendous help in assisting Jane to come to terms with it. The dichotomy between medical birth and natural birth is less contentious in

Fairbanks than it is in other places and as such, AFH&BC and its relationship with FMH is a useful model.

### 8.3 Crisis as Normal

*It's hard work, it hurts a lot, and you can do it.*

-Suzanne Stalls, quoted by England and Horowitz (1998, 120)

Both midwives and mothers repeated this quotation in interviews. Birth can be a crisis in both literal and metaphorical terms. It is useful to examine the concept of crisis in birth because birth can feel like a crisis for the mother and her family. Indeed, birth can result in an actual crisis if the mother or the baby is injured or dies. Claudia Bergmann wrote a dissertation entitled *Childbirth as a Metaphor for Crisis: Evidence from the Ancient Near East, the Hebrew Bible, and 1QH XI, 1-18*. She studied these texts and religious scriptures in great detail, establishing the birth metaphor as a consistent literary convention that has existed since ancient times. Bergmann points out that the people writing the texts, “were most likely men who observed the birth process from a distance and probably experienced it as a life-threatening event beyond their control and knowledge” (Bergmann 218). Yet despite the tone of crisis, Bergmann goes on to write that, “Both living through a crisis and giving birth are normal but at the same time extraordinary situations that most humans experience at some point in their lives” (Bergmann 2008, 218).

Midwives at AFH&BC do not downplay the intensity of birth, but they have confidence in women’s ability to work through it. Megan made particular note of this confidence and encouragement leading up to the birth in her interview. She recalled that even though she had been adamant her whole pregnancy about wanting a birth in which she could “go primal” without being told what to do or when, during the actual birth she found herself seeking permission, approval, and guidance from the midwife (Boswell 2011b). It was slightly unnerving to her that

the midwife sat across the room observing. Megan's reaction came as a surprise to her, but as she later observed, nine months of analysis and planning could counteract more than thirty years of cultural programming and doubt from her family in Texas. The midwives were a breath of fresh air because they had witnessed natural birth so many times that they truly did know that it was possible. "Birth is hard work, it hurts, and you can do it!" Megan declared. She admitted that she had needed the reassurance the midwives gave her during prenatal appointments that indeed her body was capable of birthing.

Similarly, after Abe left, Claire had not been shocked by Megan's circumstances. She was sympathetic, supportive, and non-judgmental. While Claire understood Megan's situation to be a crisis and did not downplay its impact, she also knew that Megan would be able to navigate the situation. Claire's quiet confidence was a significant source of encouragement to Megan, who went on to birth beautifully despite her circumstances.

The same confidence in the female body's ability to birth babies is exhibited with regard to complications in pregnancy and birth: they are recognized as serious, but also part of the normal range of birth experiences, as Bergmann used the term "normal."<sup>19</sup> Jane's case illustrates this well. The midwives acknowledge that complications occur, and they empower families with the confidence that they can navigate the challenges.

Perceiving complications as normal seems counterintuitive but in a value system that places great confidence in the mother's ability to birth her baby without intervention, recognition of the possibility of complications is very important. Viewing complications as normal is not to say that complications are not recognized as potentially dangerous or that they should not be treated. As

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<sup>19</sup> It is critical here to make a distinction between the midwives' use of the term "normal birth" and statements in this paper about "accepting complications as normal." The former is language used by the midwives and describes healthy, uncomplicated labors. The latter comes from Bergmann's statement that, "Both living through a crisis and giving birth are normal but at the same time extraordinary situations that most humans experience at some point in their lives." These are two different uses of the word "normal."

demonstrated by the stories above, accepting crisis as normal means that AFH&BC midwives are able to acknowledge complications and respond to them safely and professionally. Accepting the possibility of complications with this attitude helps the midwives to navigate crises because they are psychologically and professionally prepared.

This may seem like a rhetorical point, but such preparedness is important. In the mainstream medical model, the fact that some people will have complications means that standard practice includes interventions that are not necessary for most women. For example, mothers are not allowed to eat or drink during labor in case they have a cesarean, which requires general anesthesia. Likewise, Group B Streptococcus (GBS) is normally present in the vagina and intestinal tract of many women. If the bacteria overpopulates, it can cause an infection in the mother. During birth the baby can become infected. In rare cases an infection can kill the baby. Premature infants are at higher risk of infection. Consequently, the standard procedure is to treat every woman with intravenous antibiotics during labor if she tests positive for GBS, whether she has an infection or a normal level of GBS. It is now known that this practice is creating bacteria that are resistant to the antibiotics (Chohan, et al. 2006).

By acknowledging diversity and viewing complications as normal, the midwives at AFH&BC are able to continue practicing natural birth outside the hospital setting with the 90 percent of their clients for whom this model works quite well, and to safely transfer and transport those who require assistance (AFH&BC 2011; AFH&BC 2012). These examples of precautionary measures used in hospitals illustrate the stark contrast in the midwives model of care and the medical model of care. At AFH&BC, caregivers are prepared for complications, but they only intervene when complications occur. In hospitals, owing partly to fear of litigation, medical personnel intervene as a precautionary measure.

## Chapter 9: The Role of the Midwife

### 9.1 Guardians of Birth

“I was just thinking about this today. I have a job where someone else does all the work! I’m really good at sitting back and watching somebody else work! Maybe I should be doing more for my community!” Genevieve laughed (Reid 2011).

“One notes the role of intermediaries. Here, as in other ceremonies, they are intended . . . to serve as actual bridges, chains, or links—in short, to facilitate the changing of condition without violent social disruptions or an abrupt cessation of individual and collective life” (Van Gennep 1960, 48).

#### 9.1.1 Holding the Physical Space by Maintaining Infrastructure

Midwives provide the infrastructure for safe, natural birth. This infrastructure includes the building where 80 percent of AFH&BC births take place. It includes the birthing tubs, warm rooms, a bed, towels, and chairs for family members. The midwives possess the training, skills, experience, and equipment to provide prenatal care. The organizational structure bills insurance companies and interacts with the hospital and the ultrasound clinic. Without this infrastructure, OOH birth would be limited to what Claire called “elite home birthers.” The infrastructure the midwives provide makes it possible for many more people to have a natural OOH birth.

### 9.1.2 Holding the External Space During Birth

Genevieve described midwives as “guardians of birth” (Reid 2011). During the birth, the midwives take care of external factors so that the mother can focus her attention on the internal process taking place. The midwives watch over the mother, assessing the situation and observing any indications of trouble. This allows the mother to relax and helps labor to progress more smoothly, as discussed in earlier chapters.

Midwives also protect the mother from unwanted medical interventions. Midwives are not able to administer most of the interventions that OOH women seek to avoid. To mothers who seek the OOH birth experience, this is reassuring. Objections to being pressured to accept interventions during the intensity of labor is a common theme in online discussions.

Midwives can also guide other people in the room so as not to hinder the mother’s process. Sometimes family members and friends with the best of intentions can be distracting and hinder the process. Midwives are skilled at smoothing out social dynamics in the birthing room.

### 9.1.3 Holding the Political Space

Birth at AFH&BC is not an overtly political process. The political orientations of AFH&BC clients cover a very wide spectrum and birth is not spoken of in political terms. In general, neither midwives nor families interpret their births in political terms.

While prenatal care is not a political process, the style of OOH birth practiced at AFH&BC would not be possible without advocates who have waded into the political arena over the last several decades in order to make OOH birth practices legal, viable, and safe. Most of this work has occurred at the state level. Alaska has one of the most supportive legal structures for OOH birth. The



opportunity to have safe, supported OOH birth with friendly hospital backup represents years of hard work.<sup>20</sup>

Women have had to fight for authority over their own bodies and their own physiological processes. Violations of informed consent were cited by Liv in her interview and are a common objection to hospital practices raised in internet discussions. While politics are not discussed in the actual prenatal and birth process, AFH&BC as it presently exists would not be possible without this political action. In this way, the midwives are guardians of birth by holding the political space, making this style of birth possible for the families they serve. Turner's dialectic between structure and anti-structure are visible here as the structures of licensure and legality make it possible to continuously maintain a space for anti-structural rites of passage.

## 9.2 Empowerment

During participant observation one father summed up the central finding of this study in three words. How do midwives help mothers to navigate birth? They empower people. The word empowerment is ubiquitous in birthing literature, but what does "empowerment" mean in practice?

AFH&BC midwives have confidence in a woman's ability to give birth even at times when she does not. They answer questions and concerns about the process before the birth. They build trust with parents and do not violate this relationship during the intensity of labor. The midwives hold the space while people muddle through their own transformative process. They do not deny or suppress the pain with medication, but display confidence that mothers are strong enough to navigate the birth process even when things do not go exactly as planned. Families leave having faced pain and fear, knowing that they are strong and confident in their new social role. The midwives at AFH&BC do not

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<sup>20</sup> For more information on this topic, see Robbie Davis-Floyd and Christine Barbara Johnson, eds. 2006. *Mainstreaming Midwives: the Politics of Change*. New York: Routledge; and Judith Pence Rooks. 1997. *Midwifery & Childbirth in America*. Philadelphia: Temple University Press.

“deliver” babies. They attend births. Mothers give birth, babies are born, and this is empowering. Midwives do not “let” families participate in prenatal care and birth. Families grow babies and give birth, and the midwives are there to support the process. By holding the space, midwives facilitate this transformation.

## **Chapter 10: Conclusion**

### **10.1 Summary of Findings**

This thesis has argued that the midwives at AFH&BC help their clients to navigate the process of pregnancy, birth, and the postpartum period by employing a positive, holistic view of the natural, physiological process, by applying this view in practices that support the physiological process and minimize intervention, and by keeping the space in which OOH birth takes place.

The process of pregnancy, birth, and postpartum naturally fit into Arnold Van Gennep's tripartite model for rites of passage. Like Victor Turner, this thesis focuses on the transitional or liminal phase. These analytical models are useful because transition is what is achieved at AFH&BC. As the data has shown, this process is a function of both rite and passage. It is a naturally occurring process of change to which culture must respond. The rite of passage framework examines both the practices and the worldview of the cultural response to birth at AFH&BC.

Victor Turner points out that *communitas* or anti-structure emerges on the margins of culture, in the interstices of institutions, in counterculture, in religious orders, and during the liminal phase of rites of passage. As the data have shown, both Alaska and midwifery exist on the margins of culture. Alaska exists on the margin of American society while midwifery operates on the periphery of mainstream maternity care. One might even argue that the marginality of midwifery "feeds off" of the marginality of Alaska. Midwifery and Alaska intersect at AFH&BC. Spiritual and counterculture elements are also found in the mix, revealing Turner's concept of *communitas* to be a common thread among many of the different elements of AFH&BC culture. However, this state of *communitas* is not a continuous, solid state for the mothers at AFH&BC. Rather, it is more appropriate to say that the culture at AFH&BC demonstrates strong, transitional

“anti-structural tendencies” that weave through the entire liminal stage beginning at the start of prenatal care and ending just after the birth.

Turner’s *communitas* is not an exact model for the rite of passage at AFH&BC. Mothers do not remove themselves from the rest of society to live together at the birth center, nor do they submit to the absolute authority of the midwives as ritual elders. The stripping of social roles and status during the liminal phase does apply to a certain extent, however. Turner’s notion of anti-structure is useful as egalitarianism is clearly held to be very important in AFH&BC culture. Likewise, this anti-structure exists within the structure of AFH&BC, an organization that has its own internal roles and which interacts with other structured entities in the broader society, such as the hospital and insurance companies. As such, AFH&BC demonstrates very well the mutual dependence of structure and anti-structure, the dialectic relationship between the two. Rather than declaring AFH&BC to be a *communitas* and choosing anti-structure over structure, the data here demonstrate transitional, non-permanent “anti-structural tendencies” and provide a current, real-world example of Turner’s theory.

Both Victor Turner and Robbie Davis-Floyd suggested that rites of passage are potent opportunities for social change. Turner focused on how the process of “stripping and leveling” initiates to the statuslessness of the liminal phase opens the initiate to the ritual and calls into question the whole normal structure (1969, 128). Davis-Floyd described the opportunity for change resulting from the reflection and transmission of culture during this period of heightened receptivity. Liminality facilitates what Turner called “reclassifications of reality and man’s relationship to society, nature, and culture” (1969, 128-129). By having a positive view of the natural, physiological process, by employing a holistic understanding of that process, and by using practices that reflect this philosophy, the midwives and parents of AFH&BC are changing their relationship with society, nature, and culture, and passing those values on to their children. In

1992, Robbie Davis-Floyd found that most women preferred to give birth in the hospital because the medical model most closely matched their beliefs (Davis-Floyd 2003, 281). The fact that parents and practitioners are choosing an alternative ritual for maternity care at an increasing rate nationwide reflects changing beliefs in American culture (MacDorman, Mathews, and Declercq 2012, 1). Consciously or unconsciously, by choosing to use AFH&BC parents are reclaiming the quintessential rite of passage. In the process, these cultural values are being transmitted to mothers and babies. The midwives facilitate this transformation.

## 10.2 Epilogue

Since the main data collection period of this study, the birth center has continued to grow. A new apprentice has been taken on for training. Jen, who attended Liv's birth, is helping out indefinitely. Cara is now working at the front desk.

Sienna's baby was indeed a girl, but she was not born early. She was born on November 11, 2011, at home in the water. She weighed 9 pounds, 11 ounces.

Lena had her second child, a boy, at home in April 2012. She had another fast labor, giving birth shortly after the midwives arrived at her house.

After years of planning, fundraising, and hard work, AFH&BC has constructed a new building for the birth center. The first baby was born there on November 9, 2012. With all the new space, the midwives are hoping to help more clients, offer more services, and host more community events like movie nights and cooking classes.

On March 21, 2013, the American Congress of Obstetricians and Gynecologists officially recommended against elective cesarean births and against cesarean births before thirty-nine weeks of gestation without specific indications.

## References

- Alaska Bureau of Vital Statistics. 2009. *Method of delivery by facility for 2009*.  
[http://www.hss.state.ak.us/dph/bvs/birth\\_statistics/Method\\_of\\_Delivery\\_Facility/frame.html](http://www.hss.state.ak.us/dph/bvs/birth_statistics/Method_of_Delivery_Facility/frame.html) (accessed January 3, 2013).
- Alaska Family Health & Birth Center. 2011. *Welcome to the second fundraising dinner for the Alaska Family Health & Birth Center*. Fairbanks: Alaska Family Health & Birth Center.
- . 2012. *Welcome to the third fundraising dinner for the Alaska Family Health & Birth Center*. Fairbanks: Alaska Family Health & Birth Center.
- Alaska Department of Labor and Workforce Development. 2011. *2010 census demographic profile for Alaska*. Juneau: Department of Labor and Workforce Development.  
[http://live.laborstats.alaska.gov/cen/dppdfs/dem\\_profile\\_1.pdf](http://live.laborstats.alaska.gov/cen/dppdfs/dem_profile_1.pdf) (accessed February 12, 2013).
- American Congress of Obstetricians and Gynecologists. 2011. The American College of Obstetricians and Gynecologists issues opinion on planned home births. Press release (January 20).  
[http://www.acog.org/from\\_home/publications/press\\_releases/nr01-20-11.cfm](http://www.acog.org/from_home/publications/press_releases/nr01-20-11.cfm) (accessed May 4, 2011).
- Amnesty International Secretariat. 2010. *Deadly delivery: The maternal healthcare crisis in the USA*. London: Amnesty International Publications.

<http://www.amnestyusa.org/sites/default/files/pdfs/deadlydelivery.pdf>

(accessed December 6, 2012).

Andersson O., L. Hellström-Westas, D. Andersson, and M. Domellöf. 2011. Effect of delayed versus early umbilical cord clamping on neonatal outcomes and iron status at four months: A randomised controlled trial. *British Medical Journal* 343. doi: <http://dx.doi.org/10.1136/bmj.d7157> (accessed March 25, 2013).

Banta, H. D. and S. B. Thacker. 2002. Electronic Fetal Monitoring: Lessons from a formative case of health technology assessment. *International Journal of Technology Assessment in Health Care* 18 no. 4 (762-770). <http://www.ncbi.nlm.nih.gov/pubmed/12602077> (accessed April 24, 2013).

Barber E. L., L. S. Lundsberg, K. Belanger, C. M. Pettker, E. F. Funai, and J. L. Illuzzi. 2011. Indications contributing to the increasing cesarean delivery rate. *Obstetrics and Gynecology* 118 no. 1 (July): 29-38. doi: 10.1097/AOG.0b013e31821e5f65 (accessed March 25, 2013).

Bergmann, Claudia D. 2008. *Childbirth as a metaphor for crisis: Evidence from the ancient near east, the Hebrew Bible, and 1QH XI, 1-18*. Berlin: Walter de Gruyter.

Better Homes and Gardens. 1969. *Better homes and gardens baby book*. New York: Bantam Books.

Birth Without Fear Blog. 2011. Home water birth in western Australia: The birth story of Ava Lilly. <http://birthwithoutfearblog.com/2011/11/22/home-water-birth-in-western-australia/> (accessed Dec. 5, 2011).

Chohan, Lubna, Lisa M. Hollier, Karen Bishop, and Charles C. Kilpatrick. 2006. Patterns of antibiotic resistance among Group B *Streptococcus* isolates: 2001-2004. *Infectious Diseases in Obstetrics and Gynecology* 2006. doi: [10.1155/IDOG/2006/57492](https://doi.org/10.1155/IDOG/2006/57492) (accessed March 24, 2013).

CIA World Fact Book. 2009. Country comparison:: Health expenditures. <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2225rank.html?countryName=United%20States&countryCode=us&regionCode=noa&rank=2#us> (accessed January 7, 2013).

—. 2010. Country comparison:: Maternal mortality rate. <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2223rank.html?countryName=United%20States&countryCode=us&regionCode=noa&rank=136#> (accessed January 7, 2013).

—. 2012. Country comparison:: Infant mortality rate. <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html?countryName=United20States&countryCode=us&regionCode=noa&rank=173#us> (accessed January 7, 2013).

Craven, Christa. 2006. "Every breath is political, every woman's life a statement": Cross-class organizing for midwifery in Virginia. *Mainstreaming Midwives: The Politics of Change*. Robbie Davis-Floyd and Christine Barbara Johnson, eds. New York: Routledge.

Davis-Floyd, Robbie and Christine Barbara Johnson, eds. 2006. *Mainstreaming Midwives: The Politics of Change*. New York: Routledge.



Davis-Floyd, Robbie E. 2003. *Birth as an American Rite of Passage 2nd ed.* Los Angeles: University of California Press.

———. Midwives Association of Alaska Annual Conference. 2011. Palmer, Alaska. August 31 and September 1.

Daviss, Betty-Anne. 1997. Heeding warnings from the canary, the whale, and the Inuit: A framework for analyzing. *Childbirth and authoritative knowledge: Cross-cultural perspectives*. Robbie E. Davis-Floyd and Carolyn F. Sargent, eds. Los Angeles: University of California Press.

Daviss, Betty-Ann A, and K. C. Johnson. 2005. Outcomes of planned home births with certified professional midwives: Large prospective study in North America. *British Medical Journal* 330, no. 1416. doi: <http://dx.doi.org/10.1136/bmj.330.7505.1416> (accessed February 24, 2013).

Devane, Declan, Joan G. Lalor, Sean Daly, William McGuire, and Valerie Smith. 2012. Cardiotocography versus intermittent auscultation of fetal heart on admission to labour ward for assessment of fetal wellbeing. *Cochrane Database of Systematic Reviews* (15 FEB). DOI: 10.1002/14651858.CD005122.pub4 (accessed April 25, 2013).

DeWalt, Billie R., and Kathleen M. DeWalt. 2002. *Participant observation*. New York: Alta Mira Press.

Dowswell, T., G. J. Hofmeyr, A. Lawrence, L. Lewis, C. Styles. 2009. Maternal positions and mobility during first stage labour. *Cochrane Database of*

*Systematic Reviews* (Apr 15). doi 10.1002/14651858.CD003934.pub2 (accessed February 17, 2013).

England, Pam, and Rob Horowitz. 1998. *Birthing from within*. Albuquerque, New Mexico: Partera Press.

Food and Drug Administration. 2009. Drug information sheet: Misoprostol (marketed as Cytotec).  
<http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111315.htm> (accessed February 17, 2013).

Freeze, Rixa Ann Spencer. 2008. Born free: Unassisted childbirth in North America. PhD. diss., University of Iowa.

Gaskin, Ina May. 2011. *Birth matters: A midwife's manifesta*. New York: Seven Stories Press.

Gates S., E.D. Hodnett, G.J. Hofmeyr, C. Sakala. 2012. Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews* (October 17). <http://summaries.cochrane.org/CD003766/continuous-support-for-women-during-childbirth#sthash.zrBQPteX.dpuf> (accessed February 28, 2013).

Hamilton, B. E., J. A. Martin, and S. J. Ventura.. 2012. Births: Preliminary data for 2011. *National Vital Statistics Reports* 61 No. 5. Hayattsville, MD.: National Center for Heath Statistics.  
[http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61\\_05.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_05.pdf) (accessed March 25, 2013).

- Haverkamp, A. D., H. E. Thompson, J. G. McFee, and C. Cetrulo. 1976.  
*American Journal of Obstetrics and Gynecology*. 125 no. 3 (310-320).
- Hutton E.K., E. S. Hassan. 2007. Late versus early clamping of the umbilical cord in full-term neonates: Systematic review and meta-analysis of controlled trials. *Journal of the American Medical Association* 297 no. 11: 1241-1252. doi:10.1001/jama.297.11.1241 (accessed February 19, 2013).
- Impey, Lawrence, and Tim Child. 2012. *Obsetrics and Gynecology, 4th ed.* Hoboken: John Wiley & Sons.
- Indian Health Service. FAQ.  
<http://www.ihs.gov/GeneralWeb/HelpCenter/CustomServices/FAQ/>  
 (accessed February 12, 2013).
- Indian Health Service. Alaska Area.  
<http://www.ihs.gov/alaska/index.cfm?module=home> (accessed February 12, 2013).
- John, Theresa Arevgaq. 2011. Interview by Danielle Bennett. Fairbanks, Alaska. November 16. Interview video in the office of Patrick Plattet, University of Alaska Fairbanks Department of Anthropology, Fairbanks, Alaska.
- Johnson, Nathanael. 2010. For-profit hospitals performing more c-sections. *California Watch* (September 11). <http://californiawatch.org/health-and-welfare/profit-hospitals-performing-more-c-sections-4069> (accessed May 1, 2011).

- Johnson, Nathanael. 2011. Death rate from childbirth rises in California. *California Watch* (April 26). <http://californiawatch.org/dailyreport/death-rate-childbirth-rises-california-10038> (accessed April 25, 2011).
- Jowitt, M., and M. Kirkham. 2012. Optimising endorphins. *The Practicing Midwife* 15, no. 10 (Nov): 33-5. <http://www.ncbi.nlm.nih.gov/pubmed/23243831> (accessed March 25, 2013).
- Kawagley, Oscar Angayuqaq. 2010. Indigenous knowledge systems. University of Alaska Fairbanks.
- MacDorman, M. F., T. J. Mathews, and E. Declercq. 2012. Home births in the United States, 1990–2009. National Center for Health Statistics data brief, no. 84 (January). Hyattsville, MD: National Center for Health Statistics. <http://www.cdc.gov/nchs/data/databriefs/db84.pdf> (accessed March 25, 2013).
- MacDorman, M. F., F. Menacker, and E. Declercq. 2010. Trends and characteristics of home and other out-of-hospital births in the United States, 1990–2006. *National Vital Statistics Reports* 58 no 11. Hyattsville, MD: National Center for Health Statistics. [http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58\\_11.PDF](http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_11.PDF) (accessed March 25, 2013).
- Martin, J. A., B. E. Hamilton, S. J. Ventura, Michelle J. K. Osterman, Elizabeth C. Wilson, and T. J. Mathews. 2012. Births: Final Data for 2010. *National Vital Statistics Reports* 61, no. 1. Hayattsville, MD: National Center for Health Statistics. [http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61\\_01.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_01.pdf) (accessed Feb 24, 2013).

Menacker F. and B. E. Hamilton. 2010. Recent trends in cesarean delivery in the United States. *NCHS Data Brief* no. 35. Hyattsville, MD: National Center for Health Statistics. <http://www.cdc.gov/nchs/data/databriefs/db35.pdf> (accessed Feb 24, 2013).

Midwives Alliance of North America. 2012. Midwives model of care. <http://mana.org/definitions.html#MMOC> (accessed December 10, 2012).

Midwives Alliance of North America. 2011. Direct-entry midwifery state-by-state legal status. May 11. <http://mana.org/statechart.html> (accessed Feb 12, 2013).

Midwives Alliance of North America. 2010. Statement of values and ethics. August. <http://mana.org/valuesethics.html> (accessed December 3, 2011).

Mihesuah, Devon A. ed. 1998. *Natives and academics: Researching and writing about American Indians*. Lincoln: University of Nebraska Press.

National Center for Health Statistics. 1998. New study shows lower mortality rates for infants delivered by certified nurse-midwives. Press release, May 19. <http://www.cdc.gov/nchs/pressroom/98news/midwife.htm> (accessed January 27, 2013).

Rooks, Judith Pence. 1997. *Midwifery & childbirth in America*. Philadelphia: Temple University Press.

Rothman, Barbara Katz. 2006. *Laboring on: Birth in transition in the United States*. New York: Taylor & Francis.

- Smith, Linda Tuhiwai. 1999. *Decolonizing methodologies: Research and indigenous peoples*. Dunedin: University of Otago Press.
- Smyth, R. M. D., S. K. Alldred, and C. Markham. 2013. Amniotomy for shortening spontaneous labor. *Cochrane Database of Systematic Reviews*. doi: 10.1002/14651858.CD006167.pub3 (accessed February 7, 2013).
- Stapleton, S. R., C. Osborne, and J. Illuzzi. 2013. Outcomes of care in birth centers: Demonstration of a durable model. *Journal of Midwifery & Women's Health* 58: 3-14. doi: 10.1111/jmwh.12003 (accessed February 24, 2013).
- Stoeker, Randy. 2005. *Research methods for community change: A project-based approach*. London: Sage Publications.
- Turner, Victor. 1969. *The ritual process: Structure and anti-structure*. Chicago: Aldine Publishing.
- . 1974. *Dramas, fields, and metaphors: Symbolic action in human society*. Ithaca: Cornell University Press.
- Van Gennep, Arnold. 2004. *The rites of passage*. Original French publication 1909. First English edition 1960. London: Routledge.
- Wagner, Marsden. 2006. *Born in the USA: How a broken maternity system must be fixed to put women and children first*. Los Angeles: University of California Press.



Wagner, Marsden. 2003. Cytotec and off-label use. *Midwifery Today* no. 67 (Fall). <http://www.midwiferytoday.com/articles/cytotec.asp> (accessed February 28, 2013).

World Health Organization. 2003. *Essential antenatal, perinatal, and postpartum care: Training modules*. Copenhagen: Health Documentation Services WHO Regional Office.  
[http://www.euro.who.int/data/assets/pdf\\_file/0013/131521/E79235.pdf](http://www.euro.who.int/data/assets/pdf_file/0013/131521/E79235.pdf) (accessed February 23, 2013).

### **Participant Interviews**

- Boswell, Megan. 2011a. Her home, Fairbanks, Alaska, December 7.
- Boswell, Megan. 2011b. Her home, Fairbanks, Alaska, December 10.
- Carter, Sienna. 2011. A local coffee shop, Fairbanks, Alaska, October 3.
- Carter, Sienna and Genevieve Reid. 2011. Prenatal Appointment at AFH&BC, Fairbanks, Alaska, October 11.
- Donnan, Deborah. 2011a. Childbirth Preparation Class, AFH&BC, Fairbanks, Alaska, February 12.
- Donnan, Deborah. 2011b. AFH&BC, Fairbanks, Alaska, AFH&BC, December 1.
- Fischer, Lena. 2011. Her workplace, Fairbanks, Alaska, December 9.
- Reid, Genevieve. 2011. AFH&BC, Fairbanks, Alaska, AFH&BC, November 16.
- Schaefer, Talia. 2011. Her home, Fairbanks, Alaska, November 26.
- Schoenfeld, Jane. 2011. Her shop, Fairbanks, Alaska, November 10.
- Scott, Olivia. 2012. Her home, North Pole, Alaska, February 28.
- Taylor, Claire. 2011. AFH&BC Fairbanks, Alaska, AFH&BC, November 9.
- Thomas, Cara. 2011. Her home, Fairbanks, Alaska, December 7.

Interview transcripts are in the possession of Professor Patrick Plattet, University of Alaska Fairbanks Department of Anthropology.



